COUNTY OF LOS ANGELES

MARVIN J. SOUTHARD, D.S.W.
Director

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Chief Deputy Director

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Medical Director

550 SOUTH VERMONT AVENUE, LOS ANGELES, CALIFORNIA 90020

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DEPARTMENT OF MENTAL HEALTH

http://dmh.lacounty.gov

Reply To: 213-738-4978
Fax: 213-738-6455

April 6, 2011

Dear Legal Entity Directors:

The County of Los Angeles Department of Mental Health (DMH) Cultural Competency Unit has completed the 2010 Cultural Competency web-based Contractor Survey. The purpose of this survey was to solicit input from all our legal entities on cultural competency related policies, practices and procedures for strategic inclusion in the Cultural Competency Plan. A total of 122 entities were contacted to participate and 91 responded with a complete survey. We found the information gathered very useful, not only in terms of capturing specific examples of our multiple efforts to serve the diverse communities in the County of Los Angeles with culturally competent services, but also practices to reduce disparities within our system of care. Additionally, we obtained important information on lessons learned and areas in which we need the State Department of Mental Health to provide technical assistance. Many examples gathered were included in the 2010 DMH Cultural Competency Plan.

Below you will find the links to the Cultural Competency Plan and support document attachments.

http://dmh.lacounty.gov/AboutDMH/MHSA/Cultural_Competency/Documents/2010%20Cultural%20Competency%20Plan.pdf

http://dmh.lacounty.gov/AboutDMH/MHSA/Cultural_Competency/Documents/2010%20Cultural%20Competency%20Plan%20Attachments.pdf

Thank you very much for your participation. If you have any questions or concerns, please contact Gladys Lee, District Chief at the Planning, Outreach and Engagement Division at (213) 251-6801 or Gllee@dmh.lacounty.gov.

Sincerely,

Dennis Murata, M.S.W.
Deputy Director
Program Support Bureau

DM:GL:SCP

COUNTY OF LOS ANGELES

DEPARTMENT OF MENTAL HEALTH

PLANNING, OUTREACH & ENGAGEMENT DIVISION

CULTURAL COMPETENCY UNIT

2010 CULTURAL COMPETENCY PLAN
LEGAL ENTITY SURVEY
SUMMARY REPORT

SURVEY PERIOD – OCTOBER 18th – NOVEMBER 9, 2010

Marvin J. Southard, D.S.W.
Director
November 2010

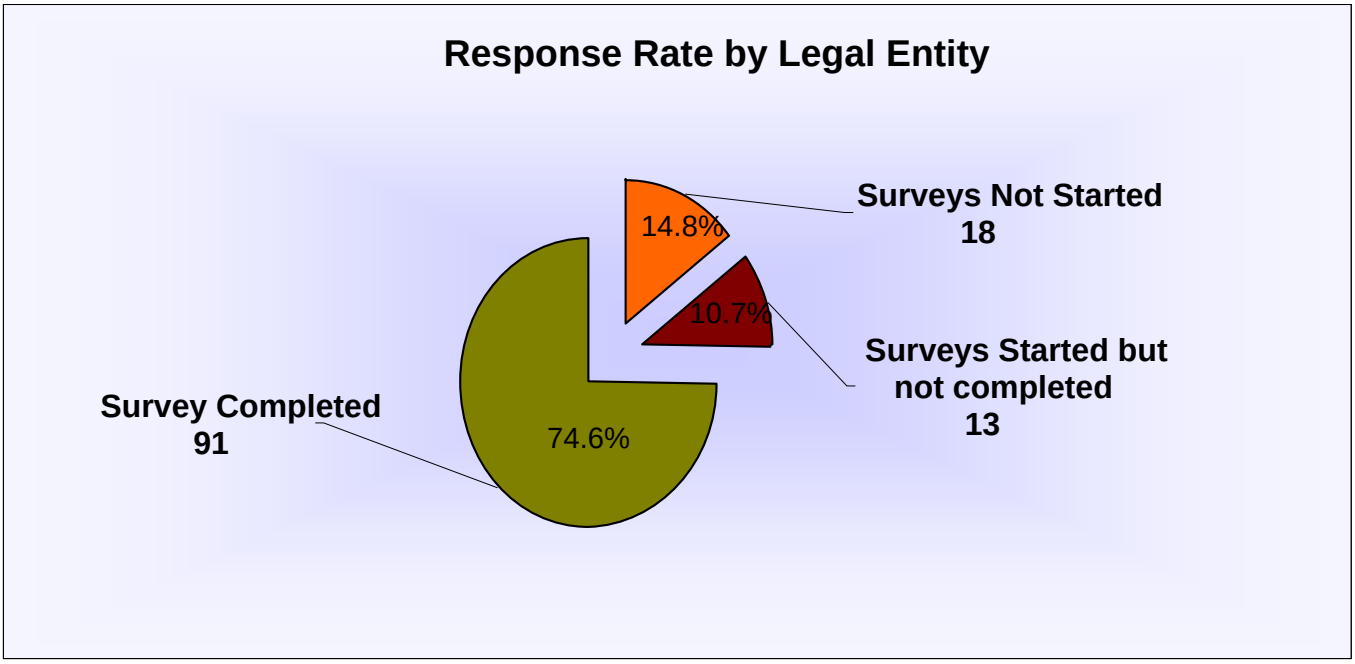
2010 Cultural Competency Plan Legal Entity Survey

Total number of Survey Participants: 122

Surveys Completed: 91

Surveys Started, but not completed: 13

Surveys Not Started: 18



2010 CULTURAL COMPETENCY PLAN LEGAL ENTITY SURVEY

1. Legal Entity Name:

Legal Entity:	Name:	Title:	Address:	Phone#:	E-mail Address
1736 Family Crisis Center	Nancy Lomibao	Director of Clincal Program	2116 Arlington Ave # 200 Los Angeles, CA 90018	310-543-9900 Ext 216	nlomibao@1736fcc.org
Alcott Center for MHS	Jessica Wilkins	Clinical Director	1433 S. Robertson Blvd	310-785-2121 Ext 205	jwilkins@alcottcenter.org
Alma Family Services	Misty Allen	Quality Improvement & Compliance Manager	1055 Corporate Center Drive #430, Monterey Park, CA 91754	323 537-1050	mistya@almafs.com
Amanecer Community Counseling Services	Tim Ryder	Executive Director	1200 Wilshire Blvd. Ste. 510 Los Angeles, CA 90017	213-481-7464 Ext 525	tryder@ccsla.org
00409	Donetta Jackson	Administrator	10012 Norwalk Blvd. Ste.110 Santa Fe Springs, CA 90670	562-906-1335	ascdjackson@aol.com
AADAP, Inc.	Hiroko Makiyama	Prevention Director	2900 S. Crenshaw Blvd. Los Angeles, CA 90016	323-293-6284	hmakiyama@aadapinc.org
Behavioral Health Services, Inc.	Shirley Summers	Chief Operating Officer	15519 Crenshaw Blvd. Gardena, CA 90249	310-679-9126	corp@bhs-inc.org
Bienvenidos Children's Center, Inc	Ericka Sagastume	Director of Mental Health	255 N. San Gabriel Blvd.	626-696-1270 Ext 231	esagastume@bienvenidos.org
Braswell Rehabilitation Institute for Development of Growth and Educational Services	Lori Pendroff	ED	1977 North Garey Avenue, #6	909-623-6651	lpendroff@bridgesrehab.org
California Institute of Health and Social Services, Inc.	William T. Marshall	President	8929 S. Sepulveda Blvd, Ste. 200, La. Ca. 90045	310-645-5227	
Catholic Healthcare West dba California Hospital Medical Center	Carolyn Heier, Psy.D.	Director, California Behavioral Health Clinic	1400 S. Grand Ave., Suite 600 Los Angeles, CA 90015	213-742-6255	carolyn.heier@chw.edu
Child & Family Center	Ari Levy, Ph.D.	Sr. V.P./Programs	21545 Centre Pointe Parkway, Santa Clarita, CA 91350	661-259-9439	ari.levy@childfamilycenter.org
Legal Entity:	**Name:**	**Title:**	**Address:**	**Phone#:**	**E-mail Address**

Child & Family Guidance Center	Kathleen Welch-Torres	Director of Programs	9650 Zelzah Avenue	818-739-5314	welch@childguidance.org
ChildNet Youth & Family Services	Corinne Gonzalez	Intake and Operations Administrator	2931 Redondo Avenue Long Beach, CA 90808	562-490-7625	cgonzalez@childnet.net
Children's Hospital Los Angeles	Karlyn Beck	Division Administrator	4650 W. Sunset Blvd., MS#115	323-361-8519	karbeck@chla.usc.edu
Children's Institute, Inc.	Steve Ambrose	Senior Vice President, Programs	711 S. New Hampshire Avenue Los Angeles, CA 90005	213-807-1804	sambrose@childrensinstitute.org
Clontarf Manor, Inc.	Peggy Weston	Project Director	18432 S Gridley Road, Artesia, CA 90701	562-860-2479	clontarfmanor.cma@verizon.net
Community Family Guidance Center	Hillary Sherman-Wicks	Clinical Director	10929 South St., #208B, Cerritos, CA 90703	562-865-6444	hshermanwicks@cfgcenter.com
Counseling & Research Assoc.	Kelly Asato	QI Coordinator	108 W. Victoria St., Gardena, CA 90248	310-715-2020	k.asato@masadahomes.org
David & Margaret Home, Inc.	Michael Miller	Director of Mental Health Services	1350 Third Street LaVerne 91750	909-596-5921	millerm@davidandmargaret.org
Dubnoff Center for Child Development	Michael Marx	Director of Clinical Services	10526 Dubnoff Way, North Hollywood, CA 91606	818-755-4950	michaekm@dubnoffcenter.org
El Centro del Pueblo, Inc	Sara Jimenez McSweyn, LCSW	Head of Service	1157 Lemoyne Street, Los Angeles, CA 90026	213-483-6335 Ext 150	smcsweyn@ecdpla.org
Emotional Health Association / SHARE!	Libby Hartigan	Program Manager	6666 Green Valley Circle Culver City CA 90230	213-213-0109	libby@shareselfhelp.org
Enki Health & Research Systems, Inc.	Heather Johnson	V.P. Clinical Services	3208 Rosemead Blvd. El Monte, CA 91731	626-227-7014	hjohnso@ehrs.com
Ettie Lee Homes, Inc.	Michelle Chiappone	Director of Mental Health	160 E. Holt Ave. Unit B, Pomona CA 91767	909-455-7501	michelle_c@ettielee.org
Exceptional Children's Foundation	Vanessa Marsot	Director of Mental Health Services	5350 Machado Rd. Culver City, CA 90230	310-773-9371	vmarsot@kayneeras.org
Exodus Recovery, Inc.	LeeAnn Skorohod	Sr VP, Operations	9808 Venice Blvd., Ste 700, Culver City, CA 90232	310-945-3350	LSkorohod@exodusrecovery.com
FamiliesFirst, Inc.	Martine Singer	Executive Director	815 N, El Centro Ave, Los Angeles, CA 90038	323-769-7100	msinger@hollygrove.org

Legal Entity:	Name:	Title:	Address:	Phone#:	E-mail Address
Filipino American Service Group, Inc.	Jeanette Sayno	Case Manager	1711 W. Temple Street	213-483-9804 Ext 205	jeanettes@fasgi.org
Five Acres	Bill Shennum	Director of Research	760 W. Mountain View St., Altadena, CA 91001	626-798-6793	bshennum@5acres.org
Crittenton Services (Florence Crittenton)	Denise Cunningham	Senior VP	801 E Chapman Ave, # 203 Fullerton, CA 92831	714-680-9075	cunningham1@cox.net
Foothill Family Service	Patricia Avery	Director of Clinical Services	2500 E. Foothill Blvd, Suite 300, Pasadena, CA 91107	626-564-1613	pavery@foothillfamily.org
For The Child	Tiffani Morton	Program Director	4001 Long Beach Boulevard Long Beach CA 90807	562-427-7671	tmorton@forthechild.org
Gateways Hospital and Mental Health Center	Michelle DeBus	Assistant Administrator	1891 Effie Street, Los Angeles, CA. 90026	323-644-2000 Ext 276	mmdebus@gatewayshospital.org
Hathaway-Sycamores Child & Family Services	David M Kirk	AVP for QA & Privacy	210 South DeLacey Avenue, Suite 110	626-395-7100 Ext 2590	davidkirk@hathaway-sycamores.org
00193	Stephen Tuffey	Program Manager	600 St. Paul Ave, #100	213-975-9091	tuffey@usc.edu
HealthView, Inc.	Michael Fitzgerald	Program Director	921 S. Beacon St., San Pedro, CA 90731	310-984-3055 Ext 3149	michaelf@hvi.com
Helpline Youth Counseling	Valerie Armstrong	Clinical Services Director	12440 E. Firestone Blvd., Ste. 1000, Norwalk, CA 90650	562-864-3722	varmstrong@vfnet.com
Heritage Clinic	Janet Yang	Clinical Director	447 N. El Molino Ave. Pasadena 91101	626-577-8480	jyang@cfar1.org
Hillsides	Antonia Aikins	Quality Management Director	940 Avenue 64, Pasadena 91105	323-254-2274 Ext 418	taikins@hillsides.org
Hillview Mental Health Center, Inc.	Jack Avila, LCSW	Clinical Director	12450 Van Nuys Blvd #200, Pacoima, CA 91331	818-896-1161 Ext 265	javila@hilview mhc.org
Homes for Life Foundation	Deborah Gibson	Executive Assistant	8939 S Seplulveda Bl #460, Los Angeles 90045	310-337-7417	dgibson@homesforlife.org
Jewish Famil;y Service	Vivian Sauer	Assoc Exec Director	3580 Wilshire Blvd	213-260-7903	vsauer@jfsla.org
Koreatown Youth and Community Center	Johng Ho Song	Executive Director	3727 W. 6th Street, Suite 300 Los Angeles, CA 90020	213-365-7400 Ext 231	johngsong@kyccla.org
Lamp, Inc	Shannon Murray	Deputy Director	526 San Pedro Street	213-488-9720	shannonm@lampcommunity.org
7211	Pia Escudero	Director	333 S.Beaudry Ave,LA 90017	213-241-3841	pia.escudero@lausd.net
McKinley Children's Center	Stacy Duruaku	Executive Director of Treatment	762 W Cypress St. San Dimas, CA 91773	909-599-1227 Ext 2525	duruakus@mckinleycc.org

Legal Entity:	Name:	Title:	Address:	Phone#:	E-mail Address
Mental Health America of Los Angeles	Erin Von Fempe	Recovery Performance Officer	100 W. Broadway, #5010 Long Beach CA 90802	562-285-1330	evonfempe@mhala.org
OPCC (Ocean Park Community Center	Christina Miller, Ph.D.	Associate Director	1453 16th St., Santa Monica, CA 90404	310-264-6646	chmiller@opcc.net
The Center Long Beach	Phyllis Schmidt	Interim Executive Director	2017 East Fourth Street	562-882-8395	Plants29@gmail.com
Optimist Boys Home and Ranch, Inc.	James Gibson	Director of Mental Health	6957 N. Figeroa St. LA 90042	323-443-3151	jgibson@oyhfs.org
Pacific Asian Counseling Services	Mariko Kahn	ED	8616 La Tijera Blvd., Ste. 200 Los Angeles CA 90045	310-337-1550 Ext 2018	mkahn@pacsla.org
Pacific Clinics	Ann-Marie Stephenson, Ph.D.	VP/Chief Clinical Officer	800 S. Santa Anita Ave., Arcadia, CA 91006	626-254-5004	amstephenson@pacificclinics.org
Personal Involvement Center	Francisco Ramirez	Mental Health Administrator	8220 south San Pedro Street, Los Angeles Ca.9003	323-565-2373	framirez@picservices.org
Phoenix Houses of Los Angeles	Elizabeth Stanley-Salazar	Vice-President, Director	11600 Eldridge Ave. Lake View Terrace, CA 91342	818-686-3015	esalazar@phoenixhouse.org
PROTOTYPES Centers for Innovation in Health, Mental Health and Social Services	Merilla M. Scott, Ph.D.	VP, Mental Health Services	2555 E. Colorado Blvd Suite 100, Pasadena CA 91107	626-577-2261	mscott@prototypes.org
Providence Community Services	Mary Ferguson-Carro	Development Manager	4281 Katella Avenue, Suite 201, Los Alamitos, CA 90720	562-467-5449	mfergusoncarro@provcorp.com
The San Fernando Valley Community Mental Health Center, Inc.	Adrienne Sheff, Psy. D. MFT	Director of Adult Services	6842 Van Nuys Blvd., 6th Floor, Van Nuys, CA 91405	818-901-4830	asheff@sfvcmhc.org
San Gabriel Children's Center	Porfirio Rincon	President/CEO	2200 E. Route 66 Suite 100 Glendora, CA 91740	626.859.2089	peterincon@sangabrielchild.com
SHIELDS For families, Inc.	Katherine Erickson	Mental Health Administrator	161 West Victoria, Ste. 255	310-603-1030 Ext 2201	kerickson@shieldsforfamilies.org
Social Model Recovery Systems, Inc.	J. O'Connell	CEO	223 Rowland St., Covina, 91723	818-802-1808	jimo@socialmodel.com
South Bay Children's Health Center Association, Inc.	Christine Byrne	Deputy Director	410 Camino Real	310-316-1212	cbyrne@sbchc.com
SPIRITT Family Services	Dustin Schiada	Clinical Director	2000 Tyler Ave South El Monte CA 91733	626-442-1400	dustins@spiritt.org
St Anne's	Heather Bays	Mental Health Services Direct	155 North Occidental Blvd Los ANgeles, CA 90026	213-381-2931 Ext 353	hbays2@stannes.org

Legal Entity:	Name:	Title:	Address:	Phone#:	E-mail Address
Saint John's Child and Family Development Center	Ruth Canas	Outpatient Director	1339 20th St Santa Monica, CA 90404	310-829-8921	ruth.canas@stjohns.org
St. Joseph Center	Nick Maiorino	Deputy Director	204 Hampton Drive, Venice, CA 90291	310-396-6468 Ext 330	nmaiorino@stjosephctr.org
Star View Adolescent Center. Inc.	Karyn L. Dresser, Ph.D.	Dir., Research & Program Practices	7677 Oakport Office Oakland, CA 94621	510-635-9705 Ext 207	kdresser@starsinc.com
Step Up on Second	Barbara Bloom	Chief Operations Officer	1328 Second Street Santa Moncia CA 90401	310-394-6889 Ext 24	barbara@stepuponsecond.org
Stirling Academy, Inc.	Chris Lewis	Administrator	31824 Village Center Rd, Suite F, Westlake Village, CA 91361	818-991-1063	clewis@stirlingbhi.org
01156	Stewart Sokol	Director	18646 Oxnard Street Tarzana CA 91356	818-654-3950	ssokol@tarzanatc.org
Tessie Cleveland Comm. Serv. Corp	Ana Mejia	Program Liaison	8019 S. Compton Ave. Los Angeles, CA. 90001	323-586-7333	anam@tccsc.org
The Children's Center of the Antelope Valley	Patricia Prado	Program Manager	45111 Fern Ave	661-949-1206 Ext 235	pprado@childrenscenter.av.org
The Guidance Center	Patricia Costales	Executive Director	4335 Atlantic Avenue	562-485-2271	pcostales@tgclb.org
The Help Group	Nicole Ryan	Director of QA	13130 Burbank Blvd, Sherman Oaks, CA 91401	818-482-1266	nryan@thehelpgroup.org
The Institute for the Redesign of Learning	Ed Shrader	Clinical Director	205 Pasadena Ave. South Pasadena, CA 91030	323-344-5538	eshrader@almansor.org
0199	Elena Judd	VP of Programs	3031 S. Vermont Ave, LA 90007	323-766-2360 Ext 3304	ejudd@lacgc.org
The Los Angeles Free Clinic dba The Saban Free Clinic	Paul Gore, Ph.D.	Director of Behavioral Health	8405 Beverly Blvd Los Angeles CA 90048	323-337-1717	pgore@thesabanfreeclinic.org
Los Angeles Gay & Lesbian Center	Diane Kubrin	Mental Heath Director	1625 N. Schrader Ave., LA, CA 90028	323-993-7432	
The Village Family Services	Terri Morgan	CAO	6736 Laurel Canyon Blvd., North Hollywood CA 91606	818-755-8786 Ext 321	tmorgan@thevillagefs.org
Tobinworld	Seth Bricklin	Director of Mental Health	920 East Broaday, glendale, 91205	818-242-8403	s.bricklin@tobinworld.org
Travelers Aid Society of Los Angeles	Laura Kassebaum	Director of Social Services	1507 Winona Blvd., LA, CA 90027	323-644-3500 Ext 15	laura@tasla.org
Tri-City Mental Health Authority	Rimmi Hundal	MHSA Manager	1717 N. Indian Hill Blvd., #B, Claremont, CA 91711	909-784-3016	rhundal@tricitymhs.org
Trinity Youth Services - El Monte	Jim Adams	Trinity El Monte Director	4026 N. Peck Rd. #204	626-444-0539	jadams@trinityys.org

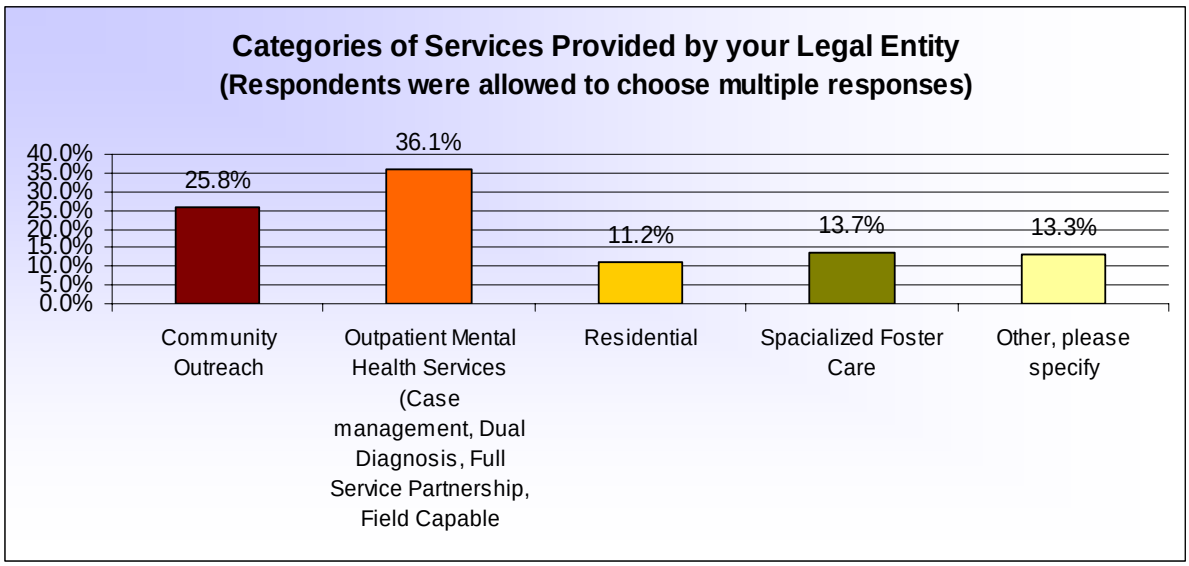
Legal Entity:	Name:	Title:	Address:	Phone#:	E-mail Address
00938	Carrie Johnson	Director	1125 W. 6th Street, LA, CA 90017	213-241-0979	drcjohnsn@aol.com
Verdugo Mental Health	Steven Hochstadt, Psy.D.	Clinical Director	1540 E. Colorado Street, Glendale 91205	818-244-7257	shochstadt@vmhc.org
VP Community Mental Health Center, Inc.	Kelly Armaly	COO	1721 Griffin Avenue, LA CA 90031	323-221-4131	karmaly@vip-cmhc.org
Westside Center for Independent Living, Inc.	Aliza Barzilay	Executive Director	12901 Venice Blvd. 90066	310-390-3611 Ext 201	aliza@wcil.org
WISE & Healthy Aging	Kathy Osburn	Administrative Director MHS	1527 4th Street 2nd Floor	310-394-9871 Ext 222	kosburn@wiseandhealthyaging.org
Eldorado Community Service Center	Jason Damavandi	Mental Health Operations Coordinator	6265 Sepulveda Blvd., Van Nuys, CA 91411	818-779-0555	
Parenting Institute	Spencer Simmons	Managing Member	6525 Belcrest Rd suite 300, Hyattsville, Md. 20782	240-882-3956	ssimmons@me.com

1. Please specify all the categories of services provided by your Legal Entity:

(Please check all that apply)

(Respondents were allowed to choose **multiple** responses)

Response	Chart	Frequency	Count
Community Outreach		65.9%	60
Outpatient Mental Health Services (Case Management, Dual Diagnosis, Full Service Partnership, Field Capable Clinical Services,Med Support, Mental Health Services, and Psych Testing)		**92.3%**	**84**
Residential		28.6%	26
Specialized Foster Care		35.2%	32
Other, please specify		34.1%	31
	Total Multiple Responses		**233**
	Total Unique Responses		**91**



(Continuation) 1. Other, please specify:

1. Wraparound, Domestic violence Services
2. MAT, PEI TFCBT/CPP/MAP
3. Wellness and Recovery Center
4. MAT, Wraparound
5. Wraparound, MAT, TBS
6. NPS, Vocational Rehabilitation, Child Care
7. Housing
8. Wellness
9. Early Start, Supported Employment, Art Centers
10. Alternative Crisis Services
11. Family Preservation, Foster Care, Wraparound
12. Inpatient
13. Non public schooling, adoption services Community Evidence Based Practices, Wraparound, Parent Partners, Public School- adjunctive mental health services
14. Transitional residential for emancipated foster youth, Wellness Center, UCCS
15. FSP, FCCS, PEI
16. Supportive housing services; Domestic violence shelter and supportive services; Emergency and transitional housing; Day program services; Benefits assistance; Advocacy; Medical care and respite program
17. MAT, CalWORKs
18. Treatment for Substance Use Disorders and Dependency
19. CalWORKs, Domestic Violence, Client Run, self help / peer support. Family Preservation, 0-5 Program & Youth & Family Center
20. THP-Plus; Wraparound; TBS
21. Child Welfare, S.A., Housing, Vocational Services, DUI, D.V.,
22. Transitional Housing
23. First 5 funded Partnership for Families
24. TEAMMATES Wraparound Program
25. WRAP, MAT, PEI
26. Wraparound, DTI, FSP, Older Adults
27. school based services
28. Wraparound, State DMH/Dept of Rehab Cooperative Program
29. Case Management
30. MHSA Programming
31. O & E, Client Run

Staff Languages

2. Does your Legal Entity provide mental health services in languages other then English?

(Respondents could only choose a **single** response)

Response	Chart	Frequency	Count
Yes		**95.6%**	**86**
No		4.4%	4
Not Answered			1
	Valid Responses		**90**
	Total Unique Responses		**91**

2a. If Yes to question 2, Which of the following languages does your staff provide services in?

(Please check all that apply)

(Respondents were allowed to choose **multiple** responses)

Response	Chart	Frequency	Count
American Sign Language		5.0%	15
Arabic		3.3%	10
Armenian		6.7%	20
Cambodian		2.7%	8
Cantonese		4.0%	12
Farsi		6.7%	20
Korean		8.0%	24
Mandarin		5.3%	16
Other Chinese		1..7%	5
Russian		6.0%	18
Spanish		**27.3%**	**82**
Tagalog		9.0%	27
Vietnamese		5.3%	16
Other: Please specify		9.0%	27
	Total Multiple Responses		**300**
	Total Unique Responses		**86**

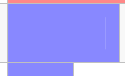
(Continuation) 2a. Other, please specify:

1. Capacity for Italian and German but no demandMAT, PEI TFCBT/CPP/MAP
2. Japanese, Samoan
3. English
4. Portuguese, Japanese
5. French, Hebrew
6. Sinhalese
7. Guajarati (Indian language)
8. Using Language Line, staffs make self-help support group and housing referrals in multiple languages.
9. Hindi; Singhalese; French; Hebrew; Japanese
10. Polish
11. Arabic, Creole, French, German, Hebrew, Hindi, Persian, Iranian, Thai, Yoruba
12. As needed- we have access to Translation Services
13. Polish
14. Lao, German, Hebrew, Yoruba, Ilocano
15. Italian, Greek
16. Japanese, Samoan and Haitian
17. American Sign Language, Bengali/Hindi, Japanese, French, Italian, Swedish, Dutch, Romanian, Croatian & Hebrew
18. Japanese
19. CURRENTLY AUDITING CAPACITY
20. Dutch, German
21. Hebrew, German
22. Bengali, Qanjobal,
23. Hebrew, Thai, Hindi, Slovak, Czech, Japanese, German, Assyrian, Turkish
24. German Czech, Portuguese, Assyrian
25. Italian
26. Dutch, Indonesian, Swahili, Hungarian, French, German, Norwegian, Persian, Iranian,
27. Use translators in American Sign Language, Spanish, Russian, Farsi

3. How many staff members in your Legal Entity currently provide mental health services in a language other than English? Please provide a count of part-time and/or full-time staff members for each language:

(Please check all that apply)

(Respondents were allowed to choose **multiple** responses)

Response	Chart	Frequency	Count
American Sign Language		6.3%	19
Arabic		4.0%	12
Armenian		6.6%	20
Cambodian		2.0%	6
Cantonese		4.6%	14
Farsi		7.6%	23
Korean		7.0%	21
Mandarin		5.0%	15
Other Chinese		2.3%	7
Russian		6.0%	18
Spanish		**26.8%**	**81**
Tagalog		8.3%	25
Vietnamese		4.6%	14
Other: Please specify		8.9%	27
	Total Multiple Responses		**302**
	Total Unique Responses		**91**

(Continuation) 3. Other, please specify:

1. 1-Italian; 1-German but no current demand
2. All other languages are mostly for substance abuse services
3. 1-Portuguese, 1-Japanese
4. 3
5. N/A All in English
6. 3 Japanese, 2 Portuguese
7. 1 Thai, 3 French, 1 Japanese. Multiple languages provided with the help of Language Line.
8. Hindi 2; Singhalese 3; French 1; Hebrew 1; Japanese 1
9. Arabic 1 ft, Creole 1 ft, French 4 ft, 1 pt, 3 per diem, German 1 ft, Hebrew 3ft, Hindi 1 per diem, Persian 2 pt, Iranian 2 pt, Thai 2 ft, Yoruba 2 per diem
10. Polish- part-time
11. Lao 1, Hebrew 1, German 1, Yoruba 1, Ilocano 1
12. Italians 1 p/t, Greek 1 p/t
13. Bulgarian: 1, Hebrew: 1, Japanese: 1
14. Japanese - 4; Samoan - 1; Haitian – 1
15. 3
16. Bengali/Hindi = 4, Tagalog = 3, Russian = 3, Italian - 2, Japanese = 2, Swedish = 1, Dutch = 1, French = 1, Croatian = 1, Romanian, 1 and Hebrew = 4
17. Japanese 1
18. CURRENTLY AUDITING CAPACITY
19. 2
20. Hebrew - 2, German – 1
21. Bengali- 1 Qanjobal- 1
22. Hebrew - , Thai - 1, Hindi -1, Slovak - 1, Czech - 1, Japanese - 1, German - 1, Assyrian - 1, Turkish – 1
23. German, Czech, Portuguese, Assyrian 1
24. Japanese, Hindi, Punjabi,
25. 1 on call LMFT (Italian)
26. Hebrew (2)
27. 8

Budget

4. Does your Legal Entity have a dedicated budget for the following services?

(Please indicate Yes or No for each Budget Item)

Budget Item		Yes	No	Total	Mean	Std Dev
1. Training staff to provide cultural and/or linguistic competent staff.	Count	**53**	36	**89**	1.404	0.494
	% by Row	**59.6%**	40.4%	**100.0%**		
2. Incentives for bi-lingual staff.	Count	**48**	41	**89**	1.461	0.501
	% by Row	**53.9%**	46.1%	**100.0%**		
3. Programs/services designated for particular ethnic client groups.	Count	31	**57**	**88**	1.648	0.480
	% by Row	35.2%	**64.8%**	**100.0%**		
4. Programs/services designated for particular language client groups.	Count	**47**	41	**88**	1.466	0.502
	% by Row	**53.4%**	46.6%	**100.0%**		
5. Programs/services for particular cultural groups (e.g., physically disabled, veterans, hearing/visually impaired, LGBTQ)	Count	27	**59**	**86**	1.686	0.467
	% by Row	31.4%	**68.6%**	**100.0%**		
Total Multiple Responses	**Count**	**206**	**234**	**440**	N/A	N/A
	% by Row	**46.8%**	**53.2%**	**100.0%**		

4a. If you answered Yes to question 4, please provide examples in the space below:

1. Spanish Speaking Domestic Violence Group and Spanish Speaking Parenting Group.

2. We do not have any special funding for training; however it is part of our general training budget done mostly by in house staff.

3. - Additional salary for bilingual MH service providers (therapists and case managers)
   - Programs are specifically designed for linguistic and cultural issues for Latino clients (and in some cases, to address distinct linguistic issues between clients from different parts of Mexico, Central America, etc.)

4. Spanish speaking clients would be assigned to Spanish speaking therapists. Curricula and the materials (e.g. handouts) are provided in Spanish and English. When Spanish speaking therapists are not available, interpreters are also available to assist monolingual clients and family members.

5. Mental Health and Case Management services provided by Bi-lingual/Bi-Cultural staff members. All BHS staff attend training on disabilities and cultural competency

6. We have staff available to provide mental health services in the clients/families native language in-home and outpatient. We have staff available to provide translation of mental health services in the clients/families native language in-home and outpatient.

7. We have tailored an evidence-based practice, Trauma-Focused CBT, for use with Spanish-speaking clients.

8. Bilingual differential pay, In-service trainings and Spanish language services and groups/classes.

9. Acculturation group, Groups, individual conducted in Spanish, Parenting, Outreach Programs in Affordable Housing complexes.

10. On going cultural training for our staff, monetary incentives and we provide services to clients that are culturally sensitive and will use therapists, case managers, etc if the client requests a certain language or culture.

11. Group therapy sessions offered only Spanish and only in English.

12. Examples of staff trainings include “Working with Latino Immigrants;” Multicultural Fatherhood;” and “Cultural Diversity.” Clinical staffs who provide direct services to Spanish or Korean-speaking clients receive a bilingual pay

differential. CII staff are selected and trained to be able to provide services that reflect the ethnic, cultural, and linguistic needs of the clients. Many individual and group services are provided in other languages, particularly Spanish and Korean. CII has a liaison with the Gay and Lesbian Center and provides linkages and support to clients and parents of LGBTQ youth.

13. The agency includes cultural issues in individual and group supervision for all clinical staff. The agency also provides a $220 annual stipend to clinical staff which can be used for relevant trainings, including those to enhance cultural competency. The agency offers a bi-lingual stipend to therapists who speak Spanish.

14. Pay differential for those who provide services in clients' threshold languages.

15. We have staff attend various cultural trainings throughout the year and bring back info to share whether it is trainings through DMH, Latino Behavioral Institute, etc. We also keep this as a focus in clinical supervision. We utilize a testing agency to verify fluency of bilingual staff and based on this they receive 2000.00 or 1500 a year extra incentive. 2000 if they are bilingual in writing and speaking, 1500 for speaking only.

16. (2)The Agency offers a stipend to bi-lingual staff.

17. 1. Onsite clinical trainings on culturally competent TFCBT (via nctsn.org) 2. Mental illness among ethnic minority children & adolescents.

18. Program Director Jason Robison and Program Coordinators Juan Moscoso and Janice Oye provides ongoing training on cultural competence, such as honoring multiple holiday traditions through signage and ceremonies; and being sensitive to food restrictions (such as not serving pork because numerous groups avoid pork). Program manager Libby Hartigan ensures compliance with the Americans with Disabilities Act (ADA) with regular reviews, staff meetings and communications. Staff attends conferences such as Alternatives and the CNMHC Forum to develop greater cultural competence. Numerous support groups are held in Spanish at SHARE! Downtown and SHARE! Culver City, including Sexual Compulsives Anonymous, Sex Addicts Anonymous, Codependents Anonymous, Kleptomaniacs and Shoplifters Anonymous, Narcotics Anonymous and Gamblers Anonymous. SHARE! Publishes countywide listings of support groups serving dually diagnosed people and survivors of childhood sexual abuse. In serving LGBTQ, SHARE! Have two gay staff members and one gay board member. At SHARE! Culver City, Sunday 4 p.m. Male Survivors of Sexual Abuse, and 6:30pm Sexual Compulsives Anonymous and at SHARE! Downtown, Friday night 7:30pm Sexual Compulsives Anonymous in Spanish predominantly serve gay men; staff also make referrals to more then 25 LGBTQ support groups dealing with a range of issues from health to parenting. SHARE! Downtown hosts an Alcoholics Anonymous meeting for Native Americans. To make self-help support groups more accessible to

people with a wide range of religious and cultural beliefs, SHARE! Denotes meetings with religious content (such as the Lord's Prayer) with an asterisk. SHARE! Also offers numerous support groups with various religious beliefs, such as Free n' One (Free from Drugs and Alcohol and One With Christ), SOS (Secular Organizations for Sobriety), Pagans in Recovery and non-12-Step groups such as Recovery International. In making referrals to self-help support groups or Collaborative Housing, staffs are trained to use the Language Line to help any non-English speaking callers. The staff is trained to connect consumers to the resources that are the most meaningful to them. SHARE!'s Collaborative Housing is designed to serve mental health consumers, and includes home that serve specific groups, such as gays and lesbians, Spanish speakers, Farsi speakers, Christians, secular people, women with children, and physically disabled. SHARE! is currently developing houses to serve diabetics and the deaf.

19. The training department provides trainings in "Cultural and Interpretive Services Training".

    Enki offers a supplement for bi-lingual staff that is providing services in a language other than English.
    Enki runs Spanish language therapy and rehab groups to serve monolingual Spanish-speaking clients.

20. Pay increase for bilingual staff. Trainings on treatment strategies in the Latino culture. In-services on treating the developmentally disabled.

21. Staff receives cultural competence training during staff meetings. WC program offers Spanish peer group.

22. Project Fatherhood group in Spanish (non-DMH-funded).

23. Deaf Services program in ASL.

24. 1. Bridging Refugee Youth & Children cultural sensitivity (BYRCS) training. Training Manager to attend training to be certified in Diversity in the workplace.
    2. Staff is given extra pay for needed/specified languages.
    3. Cultural awareness activities are conducted i.e. cultural awareness month and mental health groups focus on cultural issues.
    4. FC has monthly Foster parent meetings in Spanish.
    5. Sexually identity mental health groups are provided for needed population.

25. Staff goes to trainings about working with specific linguistic and cultural groups. In ongoing supervision this is also a part of the supervision discussion. We do pay a bonus for bilingual staff. We have parent support programs that are specific to ethnic populations and we have parent support groups in specific languages.

26. Parenting Groups in Spanish.

27. Bilingual Pay.

28. Bi-Lingual Staff receive a yearly stipend, averaged out per paycheck. Re#5- We have a Center for Grief & Loss.

29. Staffs are provided with cultural competency training through the DMH training division.

30. Diversity training for staff. Therapy for clients in Spanish. Spanish-speaking parenting workshops.

31. Higher salary for bi-lingual staff. In-home services for physically disabled and visually impaired.

32. We provide parenting groups, women's groups, and domestic violence groups in Spanish.

33. Spanish-speaking group.

34. HFLF enrolls staff in cultural competency training.

35. Programs targeting mental health needs of Russian and Farsi speaking community.

36. KYCC is part of a county-wide Asian and Pacific Islander Child Full Service Partnership collaborative. We are responsible for serving referrals that require Korean language capacity.

37. We have a transgender support group as well as HOPWA services.

38. McKinley Children's Center offers training on cultural diversity and cultural sensitive service provision.

    McKinley Children's Center will send mental health service providers to outside trainings that deal specifically with cultural issues and mental health (as trainings are made available). McKinley Children's Center offers monetary compensation for bi-lingual mental health providers. All mental health services are provided in a culturally sensitive and appropriate manner.

39. #1 Individual and group supervision, case conferences, #3 &#4 We have a program called “Un Paso Mas” and “El Centritio De Apoyo” for Spanish speaking adults.

40. Trainings are provided to staff that address cultural competence. A variety of services are provided to disabled clients (with both physical and mental health disabilities) and to veterans.

41. Asian Pacific Family Center services the needs of the diverse Asian groups. Latino Youth Program serves the Latino population and their families. Employment Services works in conjunction with the Department of Rehabilitation.

42. 1. Secure private funding and foundation funding to provide on-going training to clinical and non-clinical staff to address cultural and linguistic accessibility
2.Bilingual stipend included in hourly rate.
3. Targeted recruitment for bilingual staff
4. Intensive family services delivered in both English and separately in Spanish including ebp groups, individual and family therapy
5. Gathering families for social events, meals and special family activities and visits
6. Facility is fully ADA compliant and accessible
7. TTD capability
8. Staff is trained and policies are in place for services delivered to LGBTQ population
9. Funds available for translators for other languages as indicated.

43. Psychosocial rehabilitation groups, therapy groups, and parenting classes are provided in Spanish.

44. Language specific psycho educational groups.

45. $2,000 language differential. Programs have targeted % for ethnic populations. The Center has one mono-lingual program Manos de Espinoza.

46. If needed, services can be provided in Spanish, Korean, or Tagalog by our staff. We can also contract with others to provide services in needed languages.

47. All of SHIELDS for Families services have been developed to meet the specific cultural needs of the local communities which SHIELDS serves in SPA 6. In order to do so, SHIELDS has implemented on-going trainings designed to develop awareness and strengthen skills needed to provide culturally informed services. These trainings range from contract mandated trainings such as ADA courses to specific seminars focused on reducing disparities and racism in our communities. In addition all managers and coordinators are encouraged to focus on the issues of culture, ethnicity and sensitivity in their staff meetings, supervision and monthly staff retreats. SHIELDS have also developed specific treatment programs for Spanish speaking clients in order to meet the needs of this population in the local community. While SHIELDS

previously provided higher pay for bi-lingual staff, this practice was recently stopped as it appeared to create more disparities amongst staff. At that time all staff was given a parity increase.

48. Parenting classes in Spanish.

49. We expect therapeutic staff to participate every year in cultural and/or linguistic training. We pay for the cost of such trainings.

50. We provide the most comprehensive mental health services in the county for the Deaf and Hard of Hearing. We also have a large program that consists of individual and group therapy for individual with developmental disabilities. We offer parenting groups in Spanish and a "newcomers" group for children who have recently arrived in this country in one of our local schools.

51. Salary rates for bilingual staff are slightly higher. The agency provides education groups in both English and Spanish.
The agency operates a program specifically to/for Veterans and to the chronically homeless populations.

52. 1. We conduct annual trainings using the CBMCS curricula. We have dedicated resources to certifying trainers in CBMCS.
2. We provide a pay differential to bilingual staff that uses the non-English language in their work
3. Term "designated" requires No response. We have a number of services, including EBPs, that service distinctive cultural populations -- but ethnicity, language or culture group per se are not criteria for service enrollment.
5. Depends on how you define "culture". We have many resources dedicated to foster youth, juvenile offender populations, etc.

53. We pay bi-lingual staff an extra $5,000 in salary.

54. Yearly training on providing cultural and linguistically competent services, cultural competency is embedded in group supervision and client presentations, and staff has been trained on providing culturally sensitive translation and interpretation. Bi-lingual staff receives a sign-in bonus and higher salary. Seeking Safety is and EBP model that the agency currently services monolingual Spanish speaking families.

55. We pay more for bilingual staff, hold in-service trainings

56. Parent Groups for Spanish speaking Families, Latino Father's Group, and Multi-Cultural Family Groups.

57. 100% FSP Child staff bicultural & Bilingual Spanish speaking.

58. 1. Training budget priority is the provision of cultural and/or linguistic competent staff including staff orientation and ongoing trainings.
2. $2500 annual bilingual differential.
3. When hiring, we seek staff that reflect the community they will serve as well as having grown up in our community. This is true for all service providers, but particular emphasis has been placed on this need for our few funded parent/consumer partner positions as they are often in the position of supporting parents in participating fully in the services we provide.
4. Spanish speaking parent groups (psycho educational and support) and CalWORKs treatment groups.

59. Support groups for Spanish speaking clients. Counseling and case management services for Spanish speaking clients. Counseling for Armenian and Farsi speaking clients. Prenatal services for Spanish speaking clients. FCCS for Spanish speaking clients.

60. Spanish speaking domestic violence group for victims.

61. We have support groups for LGBTQ, Veterans, through our Wellness Center which is funded through MHSA.

62. N/A

63. Spanish-speaking Parenting classes; Armenian-speaking Parenting classes.

64. We provide many services including all out patient services in Spanish for our Latino population.

65. We have bi-lingual pay differentials and a budget line for American Sign Language interpreters. We also have many staff fluent and bi-cultural in Spanish who are utilized to ensure service to the population.

66. Our organization has designed outreach, case management and mental health services to serve the Spanish speaking populations.

5. What are some of the Policies and Procedures Documents that your Legal Entity translates into non-English languages?
(Please provide example in the space provided below.)

Policy/Procedure Title:

1. Consent, Authorization to Release info, Privacy Practices, Th/Supervisor Disclosure, Complaints and Grievances.

2. We don't translate our Policies and Procedures. We use LACDMH Policies, Procedures, Forms and Documents and the versions they have offered in Spanish and Farsi.

3. The DMH Policies and Procedures Documents that our staff use and translate into Spanish are Policy #200.2 and 200.3.

4. We do not translate internal Policies/Procedures, but rather documents, forms, instructions and other things that go out to the public.

5. N/A

6. We are currently working on translating these documents. One of our staff members attended a meeting on this topic.

7. Confidentiality.

8. Notice of new MPN- Medical Provider Network.

9. Policy # 200.2, Request for Change of Provider. 104.4# Providing Notification and Patient Information to Family. 202.26 Confidentiality.

10. Patients' Rights, Head of Service, Policy of Non-Discrimination on the Basis of Disability, Beneficiary Grievance or Appeal and Authorization Form Local Mental Health Plan.

11. All client consents, attendance policies, billing policies, releases, all HIPPA forms, releases, etc.

12. Unattended Children's Policy, HIPAA Privacy Policy and the No Show Policy.

13. Incidence Report.

14. Personnel policies are English only; Client policies in English and Spanish include: Grievance procedures, Confidentiality, Service contracts, Informed consent, Release of Information, and Client rights.

15. HIPAA, consent for treatment, policy on confidentiality (separate from HIPAA, on-call policy for programs such as FSP, FCCS.

16. HIPAA privacy notice, consent for services, Medical Beneficiary information and Grievance Policy and Procedures.

17. Clinical Record Guidelines: Contents and General Documentation Requirements Brief Description.

    Please provide a brief description in the space below. Consent for Services, Notice of Privacy Practices, Acknowledgement of Receipt, Beneficiary/Client Grievance or Appeal and Authorization form.

18. We access those Spanish language policies and procedures available via LA County DMH and make these available to clients.

19. Job application and orientation materials, volunteer orientation materials.

20. Parent/Guardian Responsibility Contract; Client Attendance Contract; Consent for Treatment.

21. None.

22. Non-discrimination policy.

23. N/A

24. N/A

25. Notice of Privacy Practices.

26. Grievance Procedure.

27. Clients Rights, Grievance Policy, Consent for Treatment, Notice of Privacy Practices, Insurance Information Form.

28. Client agreement, Consents, Releases, Information about the Agency.

29. A. Patient complaint procedure.

    B. Patient Right Handbook.

    Policy and Procedure 650.0 Patient Advisement

    Adolescent/Adult Manuals

    Patient Discharge Forms

30. No Company Policy or Procedures are in Non-English.

31. Grievance Procedures. Patient Rights literature.

32. Grievance Policy, HIPPA.

33. Policies and Procedures are all in English.

34. Consent, HIPAA form, release of information, questionnaires, termination letter.

35. We have not had the need to translate Policies and Procedures into non-English languages.

36. Privacy Practices.

37. Assessment forms, client's rights, grievance policies, HIPPA, flyers about services.

38. Welcome to KYCC, Consent for Treatment, Client Responsibilities, Notice of Privacy Practices, Authorization to Release and Request Information (Korean and Spanish).

39. Consent for Services and Policy Practices.

40. Most policies and documents are translated by our LAUSD translation unit, but due to limited staffing are restrictive to a few documents a year.

41. Intake Procedures.

42. MHALA Grievance Policy.

43. Our agency does not have written translations of policies and procedures, but Spanish-speaking staff members translate the policies and procedures verbally for Spanish-speaking clients.

44. N/A

45. All DMH forms, agency related intake forms, COA certification forms, HIPAA information and EBP materials.

46. None

47. Asian Pacific Family Center has some policies concerning service delivery and expectations that are translated in various Asian languages, e.g., Mandarin, and Cantonese

48. Mental Health Policy and Procedure Handbook, Intake forms, Medi-Cal Mental Health Services, Individual Rights in Mental Health Facilities, Grievance and Appeal Procedures.

49. Client Consents, Admission Agreements, Financial Agreements and Billing Client Rights, Staff Designations and Educational and Program Materials are translated into Spanish.

50. None

51. None

52. 1. HIPPA

    2. Content for Services

3. Admission / Intake Procedures

53. Clients are provided with any of the DMH documents that are available in their threshold language. SHIELDS have also translated the following agency policies and procedures into Spanish.

    1. Client Acknowledgement- Suspected Child Abuse or Neglect
    2. Consumer Acknowledgement- Suspected Elder and Dependent Adult Abuse and Neglect
    3. Confidentiality of Client Records
    4. Authorization for Release of Records
    5. Client Rights
    6. Notice of Privacy Practices
    7. Client Acknowledgement- Sexual Conduct Policy
    8. Client Acknowledgement- Non-Discrimination in Services
    9. Beneficiary/Client and Hearing Rights
    10. Policy and Procedures for Minors
    11. Tuberculosis Questionnaire

54. Clinic Policies and Notice of Privacy Practices.

55. Referral and Linkage.

56. Consumer Rights, Intake paperwork.

57. Consent for treatment, Medi-Cal beneficiary form, therapy contract.

58. Any/all consumer documents are translated in Spanish. There are over 25 of these at each agency that cover various types of acknowledgements and informed consent, medication protocols, program handbooks, outcome measurement tools, satisfaction surveys, etc.

59. Only those provided by DMH and only if requested by the consumer.

60. DWC-7; facts about Workers Comp; MPN notification.

61. Disability Benefits, Brochures for referrals, ROIs, Consents, admissions paperwork Questionnaires.

62. The following documents are provided: HIPPA, Clients Rights and Responsibilities, Beneficiary Grievance.

63. Intake paperwork consents, etc.

64. Policy of reporting Child Abuse, Grievance Policy.

65. HIPAA Policies, Program Brochures, Medi-Cal & Healthy Families information, Instructions to file Grievances.

66. HIPAA Consent, Consent for Treatment, Release of Information, Complaint/Grievance Procedure, Board of Psychology and Board of Behavioral Science contact information.

67. No show policy consents.

68. All policies used in service delivery, i.e. limits to confidentiality, mandated reporting, patient's rights, orientation, consent to treatment.

69. We are in the process of translating our forms to Spanish.

70. We have all pamphlets/documents required by LA DMH and Medi-Cal certification translated into about 11 languages. It is extremely rare we have a language other than English as our primary population is LA Probation adolescent males. At times, we have family members who speak primarily Spanish.

71. N/A

72. Consent for Services, HIPAA Rights, Client Care Coordination Plan, All Group Therapy Materials, Change of Provider Request Form, Attendance Policy, Request for PHI, Release of Information Consent and Any other forms upon request.

73. Consumer Rights, Authorizations to disclose/receive information, Fact Sheets about programs, Intake Forms.

74. Complaint and Grievance Policies, DMH Local Mental Health Plan and Patients Rights.

75. GRIEVANCE & APPEAL PROCEDURES.

76. Client Rights, Confidentiality and Consent.

Brief Description:

1. N/A

2. DMH Policy #200.2 is the Request of Change of Provider. A brief description of the P&P is: DMH recognizes that beneficiaries/clients have the right to request a change of provider (location) and rendering provider (i.e. psychiatrist, psychiatric social worker, case manager, etc.) to achieve

maximum benefit from mental health services. Every effort shall be made to accommodate such requests.

DMH Policy #200.3 is the Advance Health Care Directives. A brief description of the P&P is: The purpose of this policy and procedure is to be consistent with the requirements of Title 42, Code of Federal Regulations, Section 422.128 to ensure adult Medi-Cal beneficiaries served by the Los Angeles County Mental Health Plan (MHP) are provided with information concerning their rights under California State Law regarding Advance Health Care Directives and to ensure the information is updated when there are changes in State Law. It is the policy of the Los Angeles County Department of Mental Health (LACDMH) that all Medi-Cal beneficiaries over the age of 18 be given information concerning their rights under California State Law regarding Advance Health Care Directives at their first face-to-face contact for services and thereafter upon request by a Medi-Cal beneficiary. In the event a beneficiary presents a specific completed, properly executed Advance Health Care Directive, the document shall be placed in the beneficiary's mental health medical record. Provision of care is not conditioned on whether or not a beneficiary has executed an advance directive.

3. Release of Information and Privacy Notice/HIPAA.

4. Bienvenidos abides by following the policies and procedures on Grievances and Appeals.

5. This document explains that BRIDGES has obtained a new Medical Provider Network.

6. Notice for Change of Provider requests are posted in English and Spanish in lobby. Release of Information is available in Spanish and Notice of Privacy Practices.

7. These are many of the policies that we have posted in our waiting room.

8. Any policy or procedure that involves client care or is presented to a family is available in Spanish.

9. All of these policies are written in English and Spanish and made available to our Spanish Speaking clients and families.

10. Report any incidences about our clinic.

11. Samples available at your request.

12. All of the above are translated into Spanish.

13. Beneficiary Rights, Informing Materials, Consents, generally those available through DMH.

14. HIPAA privacy notice, consent for services (includes medication consent, medical beneficiary information, and grievance policies and procedures.

15. Consent for Services, Notice of Privacy Practices, Acknowledgement of Receipt, Beneficiary/Client Grievance or Appeal and Authorization form.

16. Materials for job applicants and volunteers are in English and Spanish.

17. Documents that explain parameters of the treatment agreement; limits of confidentiality; expectations for attendance, etc.

18. N/A

19. It is the policy of ECF not to discriminate on the basis of sex, religion, language, ethnicity, sexual orientation, or developmental disabilities.

20. N/A

21. HIPAA information on policies related to Protected Health Information.

22. See above.

23. Documents ensuring Patient Rights are observed.

24. N/A

25. Pamphlets are provided in the Core languages as stipulated by DMH.

26. Letter sent to client's when they no show for treatment and we have to close the case. Consent for Services is translated into Spanish. Questionnaires regarding substance use, HIPAA explanation, and release of information are all translated into Spanish.

27. Explanation of privacy standards re PHI - available in English and Spanish.

28. Pertinent policy and procedures are translated into Korean and Spanish to assist families with understanding of the treatment process.

29. Consent for Services and Policy Practices.

30. McKinley Intake procedures are translated into Spanish. This is our primary non-English speaking population. McKinley will seek to have a translator translate documents into other languages as needed.

31. This policy explains the steps for a grievance to be addressed.

32. N/A

33. N/A

34. Consent for Services.

35. Beneficiary Client Grievance or Appeal and Authorization Form, Mental Health Services Form, Initial Assessment, Intake Forms, Consent of Services Form.

36. All client consents, admission agreements, client rights, staff designations and educational and program materials are translated into Spanish.

37. None.

38. N/A

39. We will forward the documents if requested.

40. HIPAA practices notification general policies of the clinic for parents and clients.

41. P & P on the referral and linkage process as well as where to refer and link clients.

42. All intake paperwork/descriptions of services offered.

43. Intake forms are provided in Spanish.

44. Any time a consumer procedure or form is created we send it to a Spanish translator we retain on a consulting basis. For other languages we either have a staff provide the translation, or find someone in the community who can do this, on an ad hoc (as needed) basis.

45. Workers comp policies and postings.

46. Documents describing service provision, client's rights, and how to navigate the mental health system.

47. The help Group provides information regarding mandated reporting and our Grievance Policy as well as who to contact at the agency are provided in Spanish. Translation for other languages is available either by a clinician who speaks that language or via an interpreter.

48. Protection of PHI, Use and Disclosure of PHI, Client Rights.

49. We translate all documents requiring client signature into Spanish.

50. P&P are on internal intranet and not translated at this time as all staff is English speaking or bilingual.

51. Attendance document, consent for treatment.

52. Our lobby has grievance and appeal procedures and forms as well as the

Medi-Cal Mental Health Services guide translated into 11 languages. Beyond this, we have consent forms and various parent questionnaires translated into Spanish which appears to be the primary language we see outside of English at our site.

53. All policies that are applicable to consumers are offered in Spanish as well as English.

54. These are posters and/or flyers provided by the LACDMH. We do not translate; rather we provide already translated materials.

55. The above information is placed in the waiting area for all clients to review. It includes the steps in filing a grievance including where and how to file a grievance.

56. Our organization ensures that consent forms and relevant client policies (i.e. grievance, access to case records) are translated into Spanish.

6. What are some of the documents/forms/fliers/brochures that your Legal Entity translates into non-English languages?
(Please provide example in the space provided below.)

Documents/Forms/Fliers/Brochures:

1. Information on the Agency, information on CalWORKs, information on Domestic Violence.

2. We have not translated our documents/forms/fliers/brochures. We use DMH Documents, Forms, Fliers and brochures that Patient's Rights has offered in other languages including audiotapes for visually impaired.

3. Request for Change of provider form (completed by the client)
Advance Health Care Directive Acknowledgement (MH635)
Advance Health Care Directive Fact Sheet (Attachment to DMH Policy #200.3)

4. Consents, parental agreements; HIPAA confidentiality forms; financial forms & agreements; complaint forms/documents; Educational materials for groups; EBP materials such as IY curriculum and homework; internal posters and informational documents displayed in waiting areas; brochures.

5. N/A

6. Our agency brochures are available in English and Spanish. Other brochures include program brochure, and basic information on various substances abused in our communities.

7. Release of Information and Privacy Notice/HIPAA

8. Consent for Treatment, Consent for Minor, Consent for Treatment with Medication, Notice of Privacy Practices, Parent-Caregiver Questionnaire, Parent-Caregiver Responsibility Contract, Grievances and Appeals, Notice of Referrals, Mental Health Program Brochures, DMH 12 Threshold languages.

9. BRIDGES Flyers.

10. Consent of Minor, Child/Adolescent Substance Use Self Evaluation (MH 554S), Parent/Caregiver Questionnaire (MH552S), Alafia School-Based Mental Health Program & Parent/Caregiver Consent to Release Information.

11. Consent to Treatment
    HIPAA
    Cancellation Policy
    Consent to Release Information
    Medi-Cal Mental Health Services
    PFI

12. All forms/flyers for clients, some brochures.

13. All service brochures, fliers for events, notices to families regarding any changes to

14. Consent, releases, substance abuse questionnaire, Community flyers.

15. Consents
    HIPAA
    Payor of Financial Information
    Clinical Program Area Brochures

16. Consent for Treatment, Confidentiality Exceptions, Release of Information Consumer Satisfaction Surveys, Outcome Measures, and Flyers/brochures for numerous specialized services, Educational/therapeutic materials.

17. Application for services, agency brochure, FSP program brochure, website.

18. Beneficiary Rights, Informing Materials, Consents, generally those available through DMH.

19. FSP and FCCS program information, Agency information.

20. IEP letter, Closing Case letter, Final Closing Case letter Language(s).

21. HIPPA compliance, Written Informed Consent, Consent for Release of Information, Financial Obligation Agreement, Statement of Client Rights, Client Grievance Procedure Local Mental Health Plan Language Directory of Fee-For-Service Network Providers, Beneficiary/Client Grievance or Appeal and Authorization Form, Baby Safe Haven Flyer (Spanish only).

22. 1. Consent for Services
    2. Request for/Release of Information
    3. El Centro del Pueblo Program brochures
    4. El Centro del Pueblo emergency Ph #'s card

23. Collaborative Housing outreach flyers, Flyer for support group referrals by phone, SHARE! Culver City meeting directory, SHARE! Downtown meeting directory, meeting flyers, support group formats and literature, signage (such as signs indicating bathrooms and smoking policies).

24. Client Questionnaire; Consent for Treatment; Consents to Release Information; Program Information/Flyers.

25. Fliers for Foster Parent Recruitment.

26. ECF program brochures.

27. Urgent Care Center Services Flyer.

28. Agency Service Philosophy, Consent for Treatment of a Minor, Client Rights for All Programs, Summary of Privacy Practices, Authorization to Release and Exchange Confidential Information, In-Home Visits Agreement and Attendance Policy, Authorization for Electronic Correspondence with Client, Grievance and Appeal Procedures, On-Call policies, Financial Obligation Agreement, Child/Adolescent Substance Use Self-Evaluation, Parent/Caregiver Questionnaire, Child/Adolescent Substance Use Assessment and Consent to Participate in the use of Outcomes & Evaluations Instruments.

29. Consent forms for services and transportation; Patients Rights Booklet; Authorization for Release of Information; Wraparound Guide; Therapeutic Behavioral Services brochure.

30. Personal Rights, Grievances, Client Handbooks, Behavior Modification program, and Visitation Guidelines.

31. Brochures and Fliers, parent education materials.

32. Fliers about Services.

33. Psycho-educational material on psychiatric disorders.

34. Notice of Privacy Practices, Authorization to Use or Disclose Protected Information, Program Informational Flyers.

35. Intake Forms that include Notice of Privacy Practices, Informed Consent, Notice of Confidentiality, Parenting Class flyers, Client Care Plan, Application Supplement.

36. 1. Consent to Treatment
2. Mutual Release of Information
3. Telephone Information sheet
4. Geriatric Depression Scale
5. Mini Mental Status Exam
6. Notice of Privacy Practices
7. Agency brochures

37. Events, service descriptions.

38. FCCS Brochures, Wellness Fliers

39. Agency brochure, Substance Use Screening and Assessment Form, Child Behavior Checklist, Youth Self Report, major community event announcements, community resources.

40. Wellness Center Brochures and DMH Materials.

41. Psychological First Aid and other parenting handouts.

42. Intake Procedures.

43. Consent for Treatment, Consent for Medications, Un Paso Mass flyers, Project Return club meeting flyers, medication side effects (in process).

44. Sojourn (Services for Battered Women & Children) provides client satisfaction surveys in Spanish.

45. Agency brochures and Outreach flyer.

46. Several Brochures are available in the Asian languages and Spanish.

47. Consent of Services Forms, Program Brochure, Initial Assessment.

48. (1) Admission Agreement
(2) Consent for Treatment
(3) Program Orientation
(4) EBP Materials
(5) Client Rights
(6) Discharge Home Contract
(7) Announcements and Notices

(8) Special Event Notification

49. Consent for Services, Release Forms, Outpatient Clinic Agreement.

50. Program brochures and educational handouts.

51. Program brochures, clients rights, disclosure of information, client grievance policy, event fliers and On-Call Resources.

52. All brochures, Plans of Care, Safety Crisis Plans, CFT Meeting Minutes, Medi-Cal Brochures, Intake Documents.

53. Program Specific Flyers, Event Flyers, Educational Materials, Announcements.

54. 1. Agency Brochure
2. Authorization for Use/Disclosure of PHI
3. Permission to audiotape sessions
4. Acknowledgement and Consent to Services

55. Consent for Treatment, HIPAA, All Assessment paperwork, Program Brochures and All group therapy handouts, etc.

56. Fliers/Brochures describing services for all programs including Family Literacy, Transitional Housing, Mental Health Services and Partnership For Families.

57. Program brochures, community fliers.

58. Pamphlets, Release/Requests for information, Consent forms.

59. Spanish consumer rights forms and DMH multilingual poster provided by Patient's Rights office.

60. County DMH forms:
1. Substance use questionnaire
2. Intake questionnaire
3. Consent for services
4. Medi-Cal Health Services info
6. HIPAA notice of privacy practice
7. Financial Obligation agreement
8. Informed consent of provider contact
9. Attendance warning letter
10. New intake- missed appointment

61. Disability Benefits, Brochures for referrals, ROIs, Consents, admissions paperwork Questionnaires.

62. Pamphlets of services provided, CQI Brochure, and Behavior Support Management Pamphlet.

63. Forms:
    1. Confidentiality
    2. Parent Caregiver Questionnaire
    3. Beneficiary/Client Grievance or Appeal & Authorization Form
    4. Notice of Privacy Practices
    5. Flyers:
    6. Breakthrough Parenting Class
    7. Free Home-Based Services
    8. Legal Resources for Families Class
    9. It Shouldn't Hurt to Go Home
    10. Activity & Eating-Linking together for Optimal Health & Fitness
    11. Keeping Your Teens Drug-Free- A Family Guide
    12. Parents Guide to Gangs
    13. How Stress affects you & your child
    14. First 5- Preschool & Home-Based Services
    15. First 5- Building your child's self-esteem
    16. First 5- Feeling good about yourself as a parent

64. Brochures, info packages, outreach fliers, assessments.

65. Patient's Rights, Client Responsibilities, HIPAA, DMH's "Beneficiary Grievance and Appeal Forms and Procedures," DMH'S "Guide to Mental Health," Brochures about.

66. FSP Programs, School Based Out-patient. Programs, Field Based programs.

67. All Clinic program brochures that include entry procedures are translated into Spanish. For example, our one-page description of all Clinic services, our FSP-Child brochures, general outpatient brochures, Early Intervention Day Treatment Program flyer, etc. Our Clinic website (lachild.org) also has all key information about the Clinic available in Spanish, including history, mission, services, and locations.

68. Consent forms, registration forms, PHQ-9, medical history, child/adolescent addendum, COI, patient letter.

69. Program brochure, HIPPA documents, group flyer for DV services.

70. Service Description, Medi-Cal information sheet, Request for Service form and Patient Rights Forms including grievance forms and requests for provider change forms.

71. The MHSA plan was translated into Spanish and Vietnamese.

72. In Spanish, we have consent forms and parent/client questionnaires. In Spanish and about 10 other languages, we have the required grievance/complaint forms as well as the Medi-Cal Mental Health Services guide. Although we have the required forms in ten other languages, our site is limited in that most of our clients are English speaking or bi-lingual English/Spanish.

73. Any announcements or documents that are distributed to clients are translated into Spanish and Armenian. Our application for services is translated into these two languages, as are the consents and other documents requiring client signature.

74. 1. Agency Service Flier
    2. Consent for Services
    3. HIPAA Rights
    4. Client Care Coordination Plan
    5. All Group Therapy Materials
    6. Change of Provider Request Form
    7. Attendance Policy
    8. Request for PHI
    9. Release of Information Consent
    10. Any other forms upon request

75. Fact Sheets for Programs.

76. Advanced Directive Form, HIPPA Information, Flyers, Co-Occurring Disorder, Medi-Cal Mental Health Services.

77. Brochures.

Language(s):

1. Spanish
2. Spanish
3. Spanish
4. English, Spanish, Korean, Cambodian, Vietnamese, Chinese
5. Spanish
6. Spanish, English, DMH 12 Threshold Language Binder
7. Spanish
8. Spanish
9. Spanish
10. Spanish
11. Spanish
12. All of the forms are made available in English and Spanish.
13. Spanish
14. All forms presented to clients for intake, clinical assessment and treatment are available in English and Spanish. Some are available in

Korean also.

15. Spanish
16. Spanish
17. Spanish
18. Spanish
19. Primarily Spanish, however the DMH forms we keep in the waiting Room are offered in the Tagalog, Chinese, Farsi, Korean, and Arabic.
20. Spanish
21. English, Spanish, Tagalog, Farsi, Chinese, Thai
22. Spanish
23. Spanish
24. Spanish
25. Spanish
26. Spanish
27. Spanish
28. Spanish
29. Spanish and depending upon the community we are working in we have materials translated.
30. Spanish
31. Hispanic, Filipino, Chinese & Korean, Spanish
32. Spanish
33. All Core Languages
34. Spanish
35. Spanish
36. Spanish
37. Spanish
38. Farsi, Russian, Spanish
39. Korean and Spanish
40. Spanish
41. Spanish
42. Spanish
43. Spanish
44. Spanish
45. Spanish
46. Brochures - Vietnamese, Chinese, Korean, Tagalog, Samoan, Spanish, Japanese, Khmer
47. Cantonese Mandarin, Vietnamese, Spanish
48. Spanish
49. Spanish
50. Spanish
51. Spanish, Vietnamese
52. Spanish
53. Spanish
54. Spanish
55. Spanish

56. Spanish
57. Spanish
58. Spanish
59. English, Spanish
60. Spanish is routine; all others on ad hoc basis.
61. Spanish
62. Spanish
63. English, Spanish, and translation upon request.
64. Spanish
65. Spanish
66. Patient's Rights, Client Responsibilities and HIPAA - Spanish. DMH documents are available in the following languages: Arabic, Armenian, Cambodian, Chinese, Farsi, Korean, Russian, Spanish, Tagalog, and Vietnamese.
67. Spanish, Cantonese
68. Spanish
69. Spanish
70. Spanish
71. Spanish
72. Spanish
73. Spanish and Vietnamese
74. Armenian, Cambodian, Chinese, Farsi, Korean, Russian, Tagalog, Vietnamese, Spanish, Arabic, English
75. Armenian; Spanish
76. Spanish
77. Spanish, Cambodian
78. Spanish
79. Spanish

Brief Description:

1. Literature describing our programs or issues.

2. Request for change of provider form completed by the client - currently it is only in English. This form is completed by the client, requesting a change in provider and the reason for their request.

   Advance Health Care Directive Acknowledgement (MH635) - This form is given to Adult clients and asks if the client has an Advance Health Care Directive. If the client does not have one, then they are directed to the Advance Health Care Directive Fact Sheet (which is currently only available in English), which informs them on what an Advance Health Care Directive is and how they can obtain one.

   Caregiver's Authorization Form (MH646) - This form is completed by a qualified relative for consent for treatment, when the client is not in the care of their biological parents or foster parents.

3. These documents are part of the client's records and are provided in English/Spanish at the time of intake or as needed. The DMH 12 Threshold Languages binder is available and accessible to all clients.

4. A variety of program flyers, open house and activity fliers have been translated for use in the community.

5. These are the clinical documents that we use in treatment.

6. Any and all required forms for clients to complete/sign and all flyers for clients regarding services offered.

7. Consent, releases and substance abuse questionnaire and translated in Spanish if needed when a client enrolls in a program at CHildNet. Community flyers have information about our agency and the different programs we have to offer.

8. Parents giving consent to receive services from us. Form explaining their rights about HIPAA, Financial information for the parent, Program area service descriptions.

9. Samples available at your request.

10. The above documents listed are in letter form for assisting the parent with requesting an IEP and closing of case letters which is initial and final notifications of closing a client's case.

11. #. Provides a synopsis of services, eligibility criteria, and contact information

4. Provides a list of “800” numbers and other relevant phone numbers for clients and their parents.

12. Collaborative Housing outreach flyers, Flyer for support group referrals by phone, SHARE! Culver City meeting directory, SHARE! Downtown meeting directory, meeting flyers, support group formats and literature, signage (such as signs indicating bathrooms and smoking policies) are available in Spanish. The flyer for support group referrals by phone is Spanish, Tagalog, Farsi, Chinese, and Thai. Meeting directories are available in English, Tagalog, Farsi, and Spanish.

13. Forms to collect information from clients and provide program information.

14. Fliers for the community to recruit new foster parents for Adoption, Intensive Foster Care, or FFA Foster Parents.

15. What our programs offer: from early start programs for developmentally delayed infants and toddlers, to art centers for developmentally disabled, residential programs.

16. Additionally, we utilize DMH Patient's Rights materials in Spanish.

17. Agency and DMH-required intake forms.

18. Information for clients on Wraparound and TBS; various consent and authorization forms.

19. NIMN Material on depression, anxiety & schizophrenia & bipolar disorder.

20. Most forms that we give to clients have been translated into Spanish.

21. Any client events such has health fairs, holiday parties, etc. we have descriptions of the different types of programs and services we provide.

22. FCCS program description, Wellness Center events and activities.

23. Community Information and assessment tools.

24. Outreach material.

25. McKinley Intake procedures are translated into Spanish. This is our primary non-English speaking population. McKinley will seek to have a translator translate documents into other languages as needed. McKinley will also provide Spanish interpreter as needed.

26. Brochure - information about services, history and contact information. Outreach flyer in Khmer to inform Cambodians about the agency in a very simple manner.
27. Brochures describe parenting, acculturation, and substance abuse.

28. For some bi-lingual or monolingual client's therapy is done in their preferred language.

29. Will send if requested.

30. Program brochures provide an overview of each program and are used as outreach to referral sources, potential clients and the community in general. Educational handouts for clients and the community cover general topics related to mental illness.

31. All client treatment plans, safety plans, and meeting notes are available to be translated upon request of family.

32. All program and community events are announced in Spanish and English.

33. Anything a client signs is translated into Spanish and explained to the client. All contact and referral information is in Spanish.
All forms/brochures are in Spanish.

34. Program brochures are translated into Spanish. Fliers for time limited services like parenting groups are in Spanish and English.

35. Pamphlets, Release/Requests for information, Consent forms.

36. The documents explain the services offered by the agency, the agency's quality assurance process and how to engage, and information regarding Behavior Management and exclusions.

37. DMH Documents are available to clients in all languages. The Help Group provides information regarding Patients Rights (both our and DMH), Client Responsibilities and HIPAA to clients in Spanish. Translation and interpreters are available in other languages.

38. Programs services are translated into the approve languages.

39. When appropriate, flyers are English on one side, Spanish on the other. Typically, brochures are English or Spanish and when taken to fairs or other outreach activities, we have both available.

40. Group flyer for group, confidentiality agreements, program brochure.

41. It is important to note that our site will translate documents for parents who wish to keep copies of documents not already translated. Goals would be a good example of this as a parent will meet with their child and the rest of the treatment team to come up with or modify goals. Trinity will translate the document and the individualized goals into the parents' language of comfort/preference.

42. All client literature is offered in both English and Spanish upon request.

43. Fact Sheet.

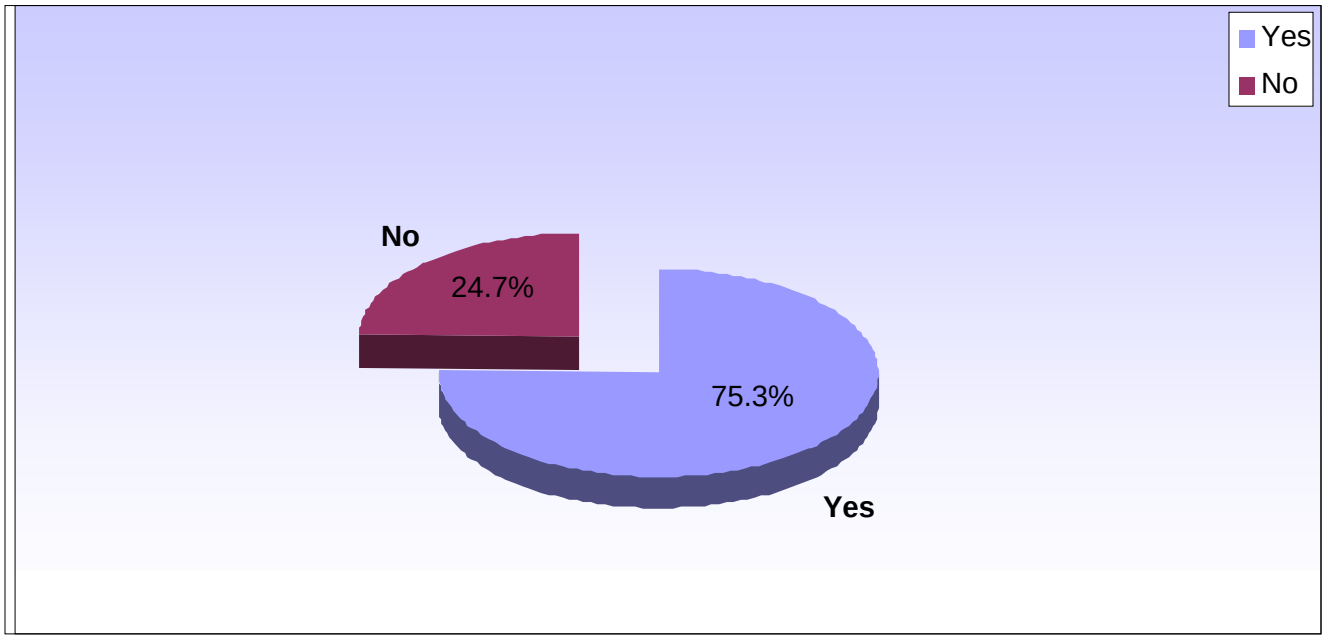
44. The Advanced Directive Form and HIPPA forms are given to the client to sign upon intake. The Co-Occurring form is used in the chart for dual-diagnosed clients. Flyers are passed with our mental health services to the local community. The Medi-Cal Mental Health Services guide is placed in the waiting area for all clients to review.

45. Our organization has translated our outreach brochure into Spanish.

6a. Sample: Do you have documents, forms, flyers or brochures available for submission?
(If you answer Yes to question 6a, please provide a contact name and phone number and we will contact you for a copy of the sample)

(Respondents could only choose a **single** response)

Response	Chart	Frequency	Count
Yes		**75.3%**	**67**
No		24.7%	22
Not Answered			2
	Mean		**1.247**
	Standard Deviation		**0.434**
	Valid Responses		**89**
	Total Unique Responses		**91**



If yes to question 6a, Please provide the name & phone number of your contact person to arrange pick-up of sample documents:

Contact Name	Contact Phone Number:
Nancy Lomibao	310-543-9900 ext. 216
Nataliz Ewalt	213-481-7464 ext. 539
Hiroko Makiyama	323-293-6284
Ericka Sagastume	626-696-1270 ext. 231
Lori Pendroff	909-623-6651
Carmen Haley	310-352-6422
Carolyn Heier	213-742-6255
Judi Best (after contacting Ari Levy)	661-259-9439
Kathleen Welch-Torres	818-739-5314
Corinne Gonzalez	562-490-7625
Marge Proctor	323-361-3870
Cynthia Thompson-Randle	213-385-5100 ext. 2019
Hillary Sherman-Wicks	562-865-6444
Kelly Asato	310-715-2020
Donna Roque	323-249-2950
Gaby Castaneda	818-755-4950
Sophia Viscarra Estrada	213-483-6335 ext. 158
Libby Hartigan	213-213-0109
Karen Cash	909-342-0907
LeeAnn Skorohod	310-945-3350
Martine Singer	323-769-7100
Bill Shennum	626-798-6793
Denise Cunningham	714-680-9075
Armine Soultanian	626 564 1613
Dr. Alvarez	323-644-2000 ext. 201
David M Kirk	626-395-7100 ext. 2590
Stephen Tuffey	213-975-9091
Valerie Armstrong	562-864-3722
Janet Yang	626-577-8480 ext. 120

Antoni Aikins	323-254-2274 ext. 481
Jack Avila, LCSW	818-896-1161 ext. 265
Nayon Kang	213- 365-7400 ext. 130
Shannon Murray	213-488-9720
Contact Name	**Contact Phone Number:**
Stacy Duruaku	909-599-1227 ext 2525
Erin Von Fempe	562-285-1330 ext 261
Christina Miller	310-264-6646
James Gibson	323-443-3151
Joycelyn Manzano	310-337-1550 ext. 2009
Lindy Russell, Public Affairs Administrative Coordinator	626-254-5000 ext. 5023
Luz Quintana	323-565-2312
ELizabeth Stanley-Salazar	818-686-3015
Merilla M. Scott	626-577-2261
Mary Ferguson-Carro	562-467-5449
Angela Kahn, Director of Quality Assurance	818-901-4830
Monica Hernandez	626-859-2089
Katherine Erickson	310-603-1030 ext. 2201
Christine Byrne	310-316-1212
Dustin Schiada	626-442-1400
Heather Bays	213-381-2931 ext. 353
Nina Qurtman	310-829-8552
Erica Lara, QA Coordinator, SVCS	562-427-6818 ext. 248
Elayne Preciado	818-991-1063 ext. 108
Dr, Ken Bachrach	818-996-1051 ext. 3806
Ana Mejia	323-586-7333
Patricia Prado	661-949-1206 ext. 235
Flaviola Gonzalez	562-485-3026
Nicole Ryan	818-482-1266
Ed Shrader	323-344-5538
Elena Judd	323-766-2360 ext. 3304
Paul Gore	323-337-1717

Diane Kubrin	323-993-7432
Helena Cerny Director of Mental Health	818-755-8786
Jim Adams	626-444-0539
Kelly Armaly	323-221-4134
Aliza Barzilay, LCSW	310-390-3611 ext. 201
Jason Damavandi	818-779-0555
Nikki Gibson	310-295-2060

7. Do any providers within your Legal Entity conduct the following activities and or procedures?

(If yes, Please provide examples in the space provided)

(Activity/Procedure)

		Yes	No	Provided Example	Total Yes/No
1. Have statements and documents that reflect that all services should be culturally competent?	Count	64	23	9	**87**
	% by Row	73.56%	26.44%		**100.00%**
2. Fund new initiatives that may better serve the culturally-specific needs of our staff and consumers and reduce disparities?	Count	32	51	6	**83**
	% by Row	38.55%	61.45%		**100.00%**
3. Recognize or compensates staff with a cultural skill, such as a second language, if they use that skill for work that is over and above their specific job duties?	Count	45	41	5	**86**
	% by Row	52.33%	47.67%		**100.00%**
4. Include a section on cultural competence in performance reviews?	Count	40	44	6	**84**
	% by Row	47.62%	52.38%		**100.00%**
5. Provide translators, interpreters, or multi-cultural staff to assist non-English speaking Consumers?	Count	79	5	13	**84**
	% by Row	94.05%	5.95%		**100.00%**
6. Have promotional and educational materials that are culturally sensitive and accessible to all consumer target groups?	Count	63	21	11	**84**
	% by Row	75.00%	25.00%		**100.00%**
7. Gather information about the demographics of the targeted consumer group?	Count	67	17	11	**84**
	% by Row	79.76%	20.24%		**100.00%**
8. Plan, develop and implement culturally appropriate service delivery	Count	64	19	5	**83**

models?					
	% by Row	77.11%	22.89%		**100.00%**
9. Evaluates the effectiveness of culturally-specific services?	Count	43	40	7	**83**
	% by Row	51.81%	48.19%		**100.00%**
10. Provide training to all staff to increase their awareness of cultural competency?	Count	74	12	11	**86**
	% by Row	86.05%	13.95%		**100.00%**

7a. If you checked *Example* for Question 7, please provide some examples in the space below:

Examples

1. 1- Statement in our Employee Handbook; 3- We pay a bilingual bonus; 4- We address this in performance review; 5- We have support staff act as translators & interpreters when we need this service. We assign staffs who have language or cultural capacity skills to clients that have the need; 7- We gather information about the consumer groups that are prominent in our Service Area.8- We aim to be culturally appropriate in our service delivery. We have a specific focus on older adult issues since we have an Older Adult Field Capable program. All our clinical staff has had courses in cultural competence and considers these factors in delivering services. We refer out to other providers if we do not have a capacity; for example we refer those who need ASL to St. John's Deaf Program. 9&10-We discuss the effectiveness of all services provided. We provided limited training to staff and used to send staff to LACDMH cultural competency trainings, however we have not seen these trainings posted in the DMH Training options for some time. We have limited capacity to train in house due to limited resources.

2. When a client calls our intake department to request services, they are asked questions about their age, gender, ethnicity, current symptoms and behaviors, etc. This information is then entered into our electronic record and a report of all of our client's demographics can be obtained.

3. Documents and educational materials are provided in Spanish; we provide translation/interpretation in Spanish/English; we gather demographics of many of our groups;

4. Our website includes statements reflecting our commitment to cultural competency. Staff members that speak languages other than English receive an incentive. While cultural competency is not one of the categories in the performance evaluation, these skills are reflected in the narratives. We have a list of staff member agency-wide who can provide assistance with various languages. Promotional and educational materials are provided in various languages. The demographic info is gathered for proposals and to enhance our overall work in the communities. FACT project in the outpatient unit was a model developed for culturally appropriate service delivery. Programs utilize outcome measures to evaluate the effectiveness of culturally specific services. Trainings and activities are available to all agency staff and the community to increase awareness of cultural competency.

5. All BHS staff attends training on disabilities and cultural competency and Cultural competency is incorporated into all clinical trainings.

6. Referral Process, Intake, Face sheet information is entered in the IS system which tracks demographics, Medi-Cal Re/Certification under Guide to Pertinent Information documents our catchment areas 3 & 7.

7. BRIDGES includes this issue in the performance review form/template.

8. 1. Regularly noted in descriptions of programs
3. Bilingual differential pay provided
5. Regularly provided by bilingual Case Managers
6. Regularly provided
7. Obtained from City and County by development arm of our agency
10. In-service presentations provided

9. Our training program brochure, performance reviews include a rating on cultural competency, translators are routinely provided for psychiatric appointments as needed.

10. we document throughout treatment that services are culturally competent, we provide training and give monetary incentives for speaking a second language, we review cultural competence throughout supervision, we provide translation if necessary, we provide culturally sensitive materials when appropriate for our clients and families, we obtain demographic information in our database, we train throughout the year and evaluate our staff to ensure they are sensitive to cultural issues.

11. When developing a training program for CHLA Mental Health Trainees, research conducted into underserved ethnic and linguistic communities in SPA4 and trainee recruitment targeted to this research.

12. CII service values, HR policies; Trained staff in Culturally Modified CBT; almost always assign clients to staff who speak their primary language; early childhood mental health materials in English/Spanish/Korean/Chinese; all models designed to be culturally appropriate; many culturally specific programs are evaluated; we offer specific trainings each year on cultural competency and ensure that all training addresses cultural issues.

13. The agency recently jointly funded a parenting group w/Kaiser for Spanish speaking parents. It has an evaluation tool to evaluate parenting satisfaction and effectives. Therapists and case managers all receive individual and/or group supervision during which cultural issues are address. Staff trainings have included cultural issues. Therapists and case managers are offered $200 annual stipends to attend relevant trainings which may include trainings on cultural issues.

14. Our case manager translates in Spanish and Brochures.

15. (3) Agency provides a bi-lingual stipend
(8) When requested, Mental Health Services are provided by service

providers who are culturally and/or linguistically competent in the requested culture and/or language.
(10) Agency Trainings include topics that are cultural specific.

16. 1. El Centro del Pueblo Policies and Procedures Manual
6. Parent Workshop materials re: psychotropic medications & parent workshop on cyber bullying and sexing.

17. SHARE!'s procedural manual, How to SHARE!, discusses how to make services culturally competent in detail, from room furnishings to signage to staff interactions. This year, SHARE! is developing houses for diabetics and the deaf. In reviews, we discuss staff's ability to connect with others in ways that are meaningful to them, including cultural competency. SHARE! Staffs use the Language Line to assist non-English-speaking consumers. SHARE! Have many materials in other languages as described above in questions 5 and 6. Each year, meeting-goers at each center are given a survey to provide feedback on the services they are receiving and how they can be approved. Staff responds to any complaint within 24 hours, and consumers who are looking for a particular resource are encouraged to help develop it (such as a pagan man starting a 12-step book study for pagans). Whenever possible, staff connects consumers to cultural competent community resources. For example Alcoholics Anonymous lists some 4,286 meetings in Los Angeles County, with 918 of them Spanish-speaking, as well as others in Armenian, Cantonese, Farsi, Finnish, French, Japanese, Korean and Russian. In weekly staff meetings, Program Coordinators and the Program Director provide ongoing training on how to best connect with others through increased sensitivity to their mental health needs, culture, language, gender, sexual orientation, background or life situation. SHARE! Goes to lengths to avoid communicating the stigma mental health consumers typically experience in institutions by creating an inviting, homey environment and interacting with people in a friendly, supportive way. SHARE! Sends staff to conferences and trainings such as the CNMHC Forum and Alternatives to increase their effectiveness and cultural sensitivity.

18. 3. Staff receives a salary supplement for providing services in a second language.
5. Enki employees 7 full-time and 2 part-time Spanish language translators to assist in the provision of services to Spanish-speaking consumers.
6. As needed Enki translates treatment psycho-educational materials in to languages appropriate to the consumer. We also purchase psycho-educational pamphlets in Spanish and a few other target languages.
7. Our internal data system tracks ethnicity/language demographics of our consumers.
8. Enki plans and develops service delivery models appropriate to the cultural/language needs of our clients. For example, we currently provide Triple P Parenting services in Spanish and some Chinese languages. We have on-going treatment groups for mono-lingual Spanish-speaking consumers.

10. Enki's training department provides a staff-training entitled "Cultural and Interpretive Services Training".

19. We have 4 Spanish-speaking clinicians, as well as two Spanish-speaking office staff available for translation during our operating hours. We increase the pay of all bilingual staff.

20. Data is collected on demographics, diagnosis and impairment levels of Deaf Services clients.

21. 1. Intake procedure
3. Is part of the job description and would be addressed in an evaluation as needed.
5. We utilized the language line and employee on call staff as needed to provide needed services.
9. General CQI process
10. Bryce and will be expanding such training.

22. We collect data on how many clients we serve by ethnic groups in addition to age range, gender and other demographic data.

23. Bilingual Staff are assigned to translate or assist non English speaking consumers; if staff is not available, call bilingual agencies to assist with translate.

24. Flyers, brochures, bi-lingual differential, directive supervision, Translation Services, flyers, Company vision includes cultural competency, supervision.

25. We provided translators, interpreters when necessary within our language capabilities, and keep a log of referrals that are referred out for other languages and cultural specific services.

26. We have developed a socialization group for elder Latinas built around knitting and crocheting.
Higher pay for bilingual staff.
Look at census data to gather information about demographics.
We provide trainings to staff 2 to 4 times a year on cultural issues.

27. We have a multi-cultural staff that bi-lingual in various languages that are able to assist non-English speaking Consumers.

28. Job postings.

29. Community demographic information that includes; race, gender, median income, linguistic isolation, immigration status, access to healthcare, educational attainment, crime.

30. We will be adding a cultural competence component to our Employee Evaluations.

31. Have healthy city.org and other District Resources, such as the Immigrant Center.

32. At time of hire, each employee receives a handbook detailing all requirements of the job to include expectations on cultural competency, diversity, and sensitivity in service provision.
Employees who are bilingual receive extra monetary compensation Translators are provided when requested and as needed.
Demographic information is collected at the time of intake.
Interdisciplinary meetings are held to address the appropriate service delivery for all clients, but also addresses any cultural/ethnicity needs. Surveys are provided to consumers to address the effectiveness of culturally specific services. In house trainings are provided on cultural competency, as well as outside trainings as they become available.

33. #2 we are constantly looking for new funding sources for Un Paso Mas and the 7 Cities Initiative, #5 in all 3 major programs, we have translation services available, #6 we have promotion materials in Spanish, #7 we collect demographic materials every month for our report card, #8 we use the "No Wrong Door" approach for each person seeking services. This approach addresses cultural competency issues.

34. Same as above. Mandate cultural competency trainings annually.

35. Demographics as to languages and population in various service areas, track clients by ethnicity.

36. Mission Statement, Pay differential for threshold language and Training - Collaborate with County and other organizations to plan and deliver Conferences and/or specific trainings through the Pacific Clinics Training Institute.

37. A translator is always available for staff to use. Cultural and competency training provided for staff, individual with bilingual abilities have been given monetary compensation for their skills and abilities.

38. 1. Accessibility Policy
2. Staff Policy
3. Bilingual Stipend
4. Interpreters on staff
5. Grants have been written reflecting community composition and need
6. Materials available in Spanish
7. Demographic data collected
8. Satisfaction surveys in Spanish/ participation numbers
9. No

10. Yes

39. 1. Part of Agency's values statement; non-discrimination policy
3. Salary scale includes compensation for second language skill
5. We have several bilingual staff available
6. Brochures and other materials
7. We collect demographic information on all of our clients – age, gender
8. Culture is part of our planning process in providing services and models
9. We do so informally based on client report
10. Cultural competency is an ongoing discussion in individual supervision, group supervision and case conferences. Staff also has the opportunity to attend outside trainings on cultural competency.

40. Gender, age, ethnicity, # served.

41. 3. Bilingual bonus of $2,000
5. All bilingual staff is available for translation as needed.
8. Center has a Cultural Competency Plan
10. Center provided an annual Cultural Competency training and staff attend outside trainings.

42. Bi-lingual staff receive pay compensation; provide translators as needed; general brochures available in Spanish.

43. 1. Examples Provided above under Policies and Procedures.
2. Our agency has opted to use recently acquired funds to pay for a lawyer who will focus on immigration rights for clients.
5. All programs have funded positions specifically for bi-lingual Spanish speaking clients.
6. Outreach information, inclusive of brochures and fliers have been prepared in Spanish.
7. Through our training and Research department demographics for the targeted consumer groups are gathered annually.
8. Shields have developed a specific Family Centered Treatment model which was designed in response to the specific needs of the local community.
9. SHIELDS conduct consumer satisfaction surveys at least two times per year. SHIELDS mental health staffs also participate in the county consumer satisfaction surveys.
10. As stated before, cultural competency is one of the core issues embedded into all of SHIELDS trainings.

44. SPIRITT collects demographics from our internal computer systems in order to provide better services to our community.

45. We have two staff trained as interpreters in Spanish (A Program Assistant and a Parent Partner). We pay for translation services monthly in the event that a therapist in the field needs translation for a family member.

46. We are required by DMH to use interpreters when necessary. We collect demographic information on Veterans and the chronically homeless populations.
We require all staff on the DMH contract to attend the County's cultural competency training at least once.

47. Each agency develops and works on a cultural competency plan annually. Their areas of focus must include: a) multi-cultural staff recruitment, retention, & training to reflect populations prevalent in their service population; b) maintaining written policies, procedures, forms, and public relations materials on cultural competency; and, c) an elective project. This year (2010), SVCS's elective, for example, is culling input from multi-cultural staff on service practices that need to be enhanced to better meet the needs of particular groups in their service population. As a result they have formed a Latino Services Committee to work on specific Latino cultural competency projects.

48. DMH and Agency Policy on Cultural Competent services to be provided. Monthly supervision that discusses the needs of specific cultural groups within the agency we request outside support for non-English speaking clients where we do not have the language within our staff such as SM Deaf Services, Jewish Family Services for Farsi speaking clients, PACS for Korean clients. Our primary population is English Speaking as a first language or Spanish speaking with competent English.

49. Sterling provides interpretation for Spanish-speaking clients if there are no Spanish-speaking therapists available.

50. Cultural competency is noted on clinical staff job description and evaluation under building rapport. All clinical staff receives training on culturally sensitive interpretation. Data is gathered by TCCSC data department on client and community demographics. Cultural competency is stressed during training, meetings, and supervisions.

51. 1 - Guidelines for Professional Conduct and Practice; 3 - Bilingual incentive; 5. - Provide translation, verbal and written, 7 - gather data annually, 10 - in-service trainings.

52. Clinical staffs are trained on cultural diversity and competence throughout the year. Annually all Help Group employees are trained in diversity.

53. Use demographic information distributed by LA Co. DMH, to design and implement programs for targeted consumer group.

54. 1. Clinic has a written set of standards of care and "pride principles" that are used to train all staff which includes expectations relative to cultural competence and sensitivity.

2. As described below, a grant to provide services to uninsured immigrant Latino families.
4. See performance appraisal for items.
5. Have translators/interpreter staff.
6. See above.
7. Annually aggregate demographic information.
8. All service planning is consumer oriented and family driven as a first step in cultural competence/sensitivity with location of services is based on consumer choice.
9. Grant funded services at Norwood Elementary School indicted statistically significant positive results. See below for further description.
10. Annually provide training to staff which is documented in the Clinic's annual Accessibility Plan.

55. Translators and language line is available and Educational materials available in Spanish.

56. Census tracking, MHSA demographic surveys SPA specific, California Endowment surveys and statistics, Children's planning council statistical data.

57. We attempt to provide services in a culturally sensitive manner. If need be, we use a translator for alternative languages to gather information from and provide information to the client.

58. Through MHSA programs.

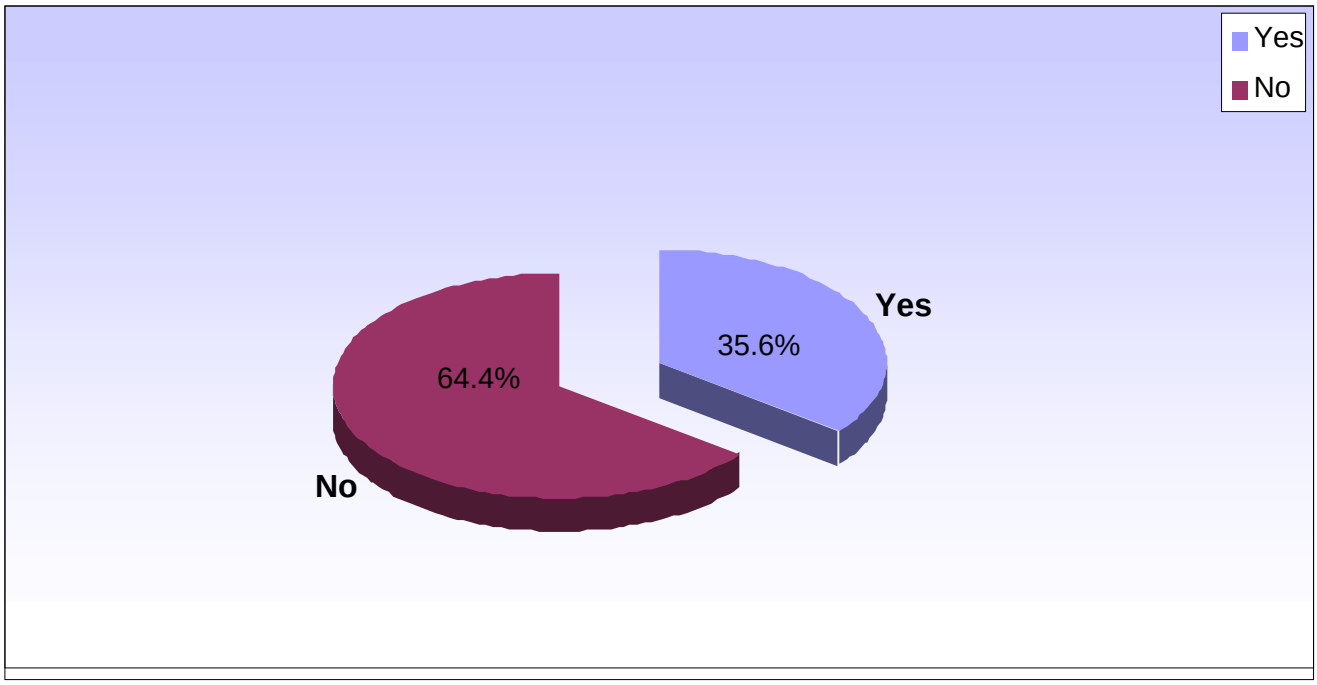
59. 1. See forms and policies in Spanish as listed in Q5 and Q6
2. We fund a mentor and tutor program which includes a learning center to better understand our clients. We have open feedback forums for our staff address their culturally specific needs. Our HR manager integrates this in her employee feedback meetings.
3. We provide bi-lingual bonus to our therapist and monthly employee recognition for work above and beyond their job.
4. This is included in our performance reviews
5. All administrative support staff are required to be bi-lingual Spanish/English and part of their job descriptions include participation in translation shifts.
7. We maintain 2 databases that were we collected demographic information and produce monthly reports to ensure that our staffs are capable of meeting the cultural needs of our clients.
8. All of our EBP materials are translated and delivered in Spanish as well as English.
9. Outcome measures are collected on both groups of clients (English and Spanish) and can be compared to each other as well as standard expected outcomes from the EBP developers.
10. We send staff to DMH sponsored Cultural Competency trainings as well as incorporate cultural sensitivity training in all supervision groups.

60. Additional Spanish speaking staff are available if necessary for a session. Non-English flyers are created and distributed to the local community. The demographics of each Service Area are known and that population's language is used for policies, flyers, documents, etc. Staffs attend Department of Mental Health trainings as well as receive CEUs which include cultural competency.
61. As part of our accreditation, we track demographic trends and are required to have annual cultural proficiency trainings.

8. Do any providers within your Legal Entity track outcomes measures/indicators/benchmarks to track cultural and/or linguistic competence for staff and/or consumers?

(Respondents could only choose a **single** response)

Response	Chart	Frequency	Count
Yes		35.6%	32
No		**64.4%**	**58**
Not Answered			1
	Mean		**1.644**
	Standard Deviation		**0.481**
	Valid Responses		**90**
	Total Unique Responses		**91**



8a. If you answered Yes to question 8, please provide some examples for consumers and staff in the space below:

(Respondents were allowed to choose **multiple** responses)

Response	Chart	Frequency	Count
Consumers: Please specify		**29.7%**	**27**
Staff: Please specify		26.4%	24
Out of the 32 Legal Entities who said "Yes" to question 8.		**Total Multiple Responses**	**51**
		Total Unique Responses	**32**

Consumers:

1. Client Satisfaction Survey after Spanish Speaking Parenting Group.
2. Not sure I understood the question.
3. Client surveys done 1-2 times/year ask specifically if Amanecer staff were culturally and linguistically competent.
4. Cultural Competency Report.
5. Cultural Competency Log.
6. Utilized Evidenced Based Practices in diverse languages.
7. Consumer surveys to evaluate client perceptions of staff cultural competency.
8. State Performance Outcome Measures.
9. Annual survey of meeting-goers.
10. Language Specific services requests.
11. We canvassed our parent advisory board about our ability to meet their cultural competency expectations.

12. We track the language and culture of each client by asking them their primary language and the culture that they identify with. It is put in the data base to compare all clients the year.

13. Our quality department sends surveys to consumers, and stakeholders.
14. Consumer survey.

15. MHSA – OMA.

16. We track the language preferences of consumers.

17. We track language/ethnicity of consumers.

18. Satisfaction Surveys incl. Cultural Questions.

19. ASEBA outcome measure.

20. Track CAPIT - Monthly Log for Language & Culture Specific Mental Health Services.

21. Client surveys.

22. Send out to consumers, Consumer Satisfaction survey, which gets feedback on consumer opinion of services regarding cultural competence.

23. Satisfaction surveys.

24. Cultural identify scales, participation in cultural events.

25. Consumers and caregivers are specifically asked and analyzed for their ability to understand English. If deficiencies are found, staff consults to determine if the family will be better served w/ a Bi lingual therapist.

26. Surveys are passed out biannually.

27. Number of clients served.

Staff:

1. Outcome Measures Surveys that are conducted 2 times a year by DMH. Once the surveys are completed, one staff member at Alma reviews the answers received and reports to our Executive Staff the outcomes.

2. We complete the local SBE form annually.

3. Neg Pkg Schedule 6 Personnel Staff Languages.

4. Bilingual staff required to pass language competency exam of LA Dept of MH.

5. Staff enjoys bilingual differentials and participates in training for bilingual mental health professionals.

6. WFI.

7. We utilize a third party to verify that they are bilingual in the stated language. Staff are tested for written and language fluency.

8. Performance reviews, Personnel Item Control submitted to DMH biannually.

9. We completed an agency-wide cultural competency survey this year to benchmark our level of competence.

10. Part of competency, performance evaluation.

11. We track staff languages spoken.

12. Intake statistics.

13. Organizational Climate Survey.

14. We track language and ethnicity of staff. We maintain records of trainings specific to cultural or linguistic.

15. Quality/fidelity probes focus on Cultural Competency.

16. Performance evaluation.

17. Outcome measures, language aptitude tests.

18. Track number of Spanish speaking clients that are served.

19. Via items on semi-annual client evaluation of services.

20. DMH cultural capacity survey.

21. Cultural training needs.

22. Employees claiming bi-lingual capabilities are tested at the point of interviewing with the agency. The agency sets a high standard at the point of hire. Their skills are periodically evaluated and assessed.

23. Training hours received.

8a. If you answered Yes to question 8, please provide some examples for consumers and staff in the space below:

1. Conducting Client needs surveys.

2. We obtain feedback from our reception and intake staff regarding requests for services. Staff meetings address consumer needs and any unmet service gaps.

3. A comprehensive assessment of the family/child's needs is included in our assessment process and then administered again as part of the ongoing effort to identify and respond to gaps in services needs. Bilingual skills are critical in identifying gaps in service needs as parents are sometimes unable or resistant to express their needs in a second language (English). Also, our staffs consult with providers in other programs (for example, therapist consults with TBS coach to discuss client's behaviors in the school and in the home to determine whether client can benefit from a psychiatric referral, etc).

4. For Individuals: gaps in service needs are defined during the assessment, annual assessment times and anytime individual goals change. We do our best to fill these gaps internally or by linking externally to providers with specific needed expertise.

   Program or Agency-Wide: At various times throughout the year and especially at annual Plan and Budget, we analyze unmet client needs. We take input from staff, from our client's surveys to identify stated needs. We also look at client outcomes to identify what service needs are not being met.

5. In meeting discussions.

6. We as an agency continue to evaluate service needs through our own work, as well as by collaborating with other agencies to determine these gaps.

7. Conduct risk analysis/needs assessment. Have annual Agency wide cultural competency plan with goals and objectives.

8. Providers determine gaps in services based on the waiting list and time-frame. Provider will make appropriate referrals to other providers with a shorter waiting list to reduce the gaps in services the client is in need of.

9. Through a needs and services plan and assessment. Further identification of gaps in services is found through the provision of intensive case management, family involvement, case conferences and treatment planning. We are planning to survey our clients by end of the year relative to the issue of cultural and/or language needs.

10. Make phone calls to clients to get feedback on clinician care, appropriateness, efficiency of services provided.

11. All of our non-speaking clients are Spanish-speaking, for which we have ample coverage at our clinic. We do not get requests for therapy in other languages but if we did we would be able to identify other agencies that provide appropriate services to other linguistic/cultural groups.

12. Feedback from clients provided to therapists and on outcome measurement forms, and community members providing feedback in bi-monthly meetings.

13. Center staffs are very involved in the local SAAC, MHSA planning meetings and needs assessment, local community school meetings, etc. Based on content of meetings with clients, stakeholders, etc. gaps in programs are identified and addressed. Our Community Family Center in Park Parthenia was established in response to community demand for services. We have a Community Advisory Committee.

14. We have ongoing audits throughout our QI department as well as ongoing supervision.

15. Targeted recruitment, salary differentials, linguistic/ethnic focus to training.

16. Developed Community Advisory Council; Developed parent leadership group for early childhood programs.

17. The agency is currently conducting a formal needs assessment in the community to determine these. Staffs have been surveyed, and the agency's Program Committee has discussed these as well. This committee includes members of other local social service agencies, staff input and Board input.

18. As staffs become aware of gaps in service needs they will bring them to supervisor’s attention so brainstorming can take place to work on identifying resources to meet the need.

19. DMH Navigator referral requests, MAT referral requests Clients requests, Community referral requests.

20. Via weekly group supervision clinical case presentations and discussions Via individual supervision. For example, since our staffs are not trained to administer the 0 - 5 assessment instrument, we will assess and refer these clients to other mental health providers. For example, since we do not provide TBS services, we link with other mental health provider agencies that can do this in order to have these services provided.

21. Attendance at DMH meetings such as SAAC 4 and 5, the Mental Health Commission and Systems Leadership Team often alerts SHARE! to gaps in

services needs, such as the Commission's recent identification of the elderly as an underserved group. Consumers who call or come to SHARE! Express needs for particular services, or report such needs in the annual survey of meeting-goers conducted at each SHARE! site.

22. Providers are sensitive to the needs of the populations we serve. For example, we have a growing Asian-speaking population in our El Monte clinic. We have made efforts to hire clinicians who speak several different Asian dialects. Staff can provide culturally/language competent services in the consumers first language and translate treatment forms/materials as needed.

23. Ongoing monitoring through Multi-Disciplinary Team Meetings.

24. We hire based on our gaps in service needs. We just hired a male Spanish-speaking clinician, as we had heard the need from the clients we serve.

25. Client service needs are indentified during intake and addressed.

26. We monitor the demographics of our clients, and ensure that we hire and retain staff that can deliver culturally sensitive services, preferably in the family's primary language. If staff is not fluent in that language, we provide translation services by staffs that have completed the DMH training. We have a Parent Advisory Board that meets regularly to review significant programs, policies and other issues to be sure we are taking into account, among other things, the cultural needs and preferences of consumers.

27. Through a comparison of language and cultural appropriate services provided by area agencies (government and private non-profit) versus community needs as indicated in community needs surveys.

28. Community surveys and analysis of waiting lists.

29. Continuous Quality Improvement process.

30. By the languages that potential clients are requesting, community needs assessments, our Strategic Planning process, client feedback and our Client Advisory Group.

31. Intake coordinator and Program Director track request for languages at intake.

32. The analysis of discharge survey forms completed.

33. Referrals and ACCESS hotline.

34. In conjunction with DMH through Executive Provider meetings and QIC meetings.

35. We have a consumer council to help define and inform consumer needs, which reports those needs to the Program Director.
The program and support staff is multi-racial, multi-lingual and as a team share information about practices which ensure sensitivity to ethnic and cultural issues. We utilize a multidisciplinary treatment team to determine plan efficacy.

36. We would determine a gap exists based on the availability (or lack thereof) of our bi-lingual staff to accept new clients.

37. We look at the demographics of our Service Areas, and compare them to the culture and language abilities of our staff. Where there are gaps, we seek to hire staff who will be able to be an appropriate cultural and linguistic match. For example, as we saw that there are many unsaved Armenian older adults, we hired an Armenian speaking clinician.

38. Information provided by client satisfaction surveys, consulting with community leaders, and other agencies.

39. The only gaps are related to lack of funding.

40. Through team discussion in weekly meetings.

41. Satisfaction surveys and anecdotal materials.

42. We are implementing a program evaluation to review and assess this area.

43. Surveys, Information and feedback from staff and clients.

44. Our Quality Department will administer surveys to consumers and stakeholders. The date is used to determine gaps in services needed, and a correction plan is put in place to compensate for any deficits. Weekly supervision is conducted with all service providers to discuss any issues that may arise in mental health services provided. At this time, if needed, the supervisor will develop and/go over any changes that are needed in the treatment plan.

45. We conduct periodic Gap Analysis on the programmatic level.

46. All projects have client feedback and satisfaction surveys and processes.

47. Evaluate what populations we serve and do not serve.

48. Our focus is to provide linguistic access by having a diverse bilingual staff for APIs so employees are tracked for linguistic skills. We track requests for languages from clients and work to maintain or add languages through our

triage officers. PACS also networks with a wide range of API agencies to see new and emerging populations and their needs.

49. When there is a referral for a consumer that we are unable to serve, for example, Sign Language.

50. By conducting random surveys to clients and their families.

51. We are a CARF accredited organization and complete Three Year Strategic Plan as well as Annual Performance Assessments and Plans that identifies gaps in service needs.

52. Our intake specialists track requests for services from the community. In our Quality Management meeting we examine any gaps in service needs. Direct service staffs also report in weekly meetings and to their supervisor any service gaps that they become aware of when providing services to clients.

53. By collecting and analyzing results of State Performance Outcomes Measures as well as internal monitoring tools.

54. QA/QI Committees meet weekly to review client medical records and indentify client needs, which include examination of levels of care, medical necessity and effectiveness of treatment.

55. Weekly meetings to discuss treatment trends and needs.

56. SHIELDS for Family operate as a comprehensive service provider, therefore as disparities and gaps in services are discovered, the agency administration works to identify and obtain available resources that can be used to fill in these gaps. In addition, staffs are encouraged to develop systems and services which can help to reduce the gaps at the local level. For example at one of our school based sites the staff developed an after-school reading program which assisted children who were performing below grade level in their reading.

57. Based on feedback provided by consumers or potential consumers either to administrative staff, therapist staff, or management.

58. We examine the needs of our surrounding community. We host collaborative meetings with our community partners in order to get their feedback on what is needed.

59. Providers meet with administrative staff daily for 4 days of the week to discuss clinical issues and program needs. Providers also have weekly clinical supervision with an LCSW to discuss client needs.

60. Every case is presented to a multi-disciplinary team in which culture is addressed as part of the overall clinical work.

61. Staffs to client demographic analyses are conducted annually.

    Outcome reports unpack results by gender, age, & ethnicity.
    Cultural competency QA probes results are reviewed for QI.
    Consumer surveys are reviewed for QI.
    Family focus groups are run periodically.

62. Identify on intake any family or individual language needs by Service Coordinator and Intake Coordinator. Brought to Program Manager to identify resources.

63. Satisfaction surveys, Focus groups, suggestion forms.

64. Through the CQI process: biweekly CQI committee meetings, program based teams (PBTs), and program action teams (PATs). This is also done through the analysis of agency (client and staff) data.

65. If there are gaps in services, the provider will follow up with the client/caregiver by phone or letter to identify the problems/issues that may be interrupting treatment.

66. Wait list review, review of client data versus community data, review of client data versus staff data.

67. Gaps in service are identified through client surveys where clients are called by a non-clinician and asked questions regarding delivery of service, client access, and cultural competency. Information gleaned is shared with program directors and trainings are enhanced to meet identified needs.

68. Utilize consumer and staff feedback to decrease gaps in service needs.

69. Annual Accessibility Plan identifies barriers to services including gaps in services and plans for improvement.

70. Not sure.

71. Case conferences, QA meetings, annual planning, treatment planning meetings, and strategic planning.

72. Teaming and cross walking between internal programs and liaison with local CSWs, POs, teachers, etc.

73. We regularly survey parents (in English and Spanish) asking them to indicate services they would like to have.

74. We recently conducted both community wide and client needs assessment surveys.

75. Through MHSA data collection for CSS.

76. We have a weekly meeting attended by all therapists, the biller, office staff, the QA, and the Clinical Coordinator. Program or case specific deficits are discussed to address improvements/corrections. At this time, we are learning to apply our EBP where appropriate and budget our CGF funds in a way that allows us to be more flexible with the cases that need special attention but cannot be served by the EBP in which we are trained.

77. Satisfaction questionnaires, surveys, advisory boards, community input.

78. Review of client demographics from our referral data collection and well as information gathered within intake procedures.

79. Comparison to Census data to actual consumer breakdown of those WCIL services.

80. We collect demographic data and regularly review the level of requests for services provided in languages other than English.

81. Based on the surveys handed to the clients.

82. Gaps in service delivery are determined through the Quality Assurance team and continuum.

9. How do providers in your Legal Entity determine gaps in services needs?

Please provide examples in the space below.

1. Conducting Clt needs surveys.

2. We obtain feedback from our reception and intake staff regarding requests for services. Staff meetings address consumer needs and any unmet service gaps.

3. A comprehensive assessment of the family/child's needs is included in our assessment process and then administered again as part of the ongoing effort to identify and respond to gaps in services needs. Bilingual skills are critical in identifying gaps in service needs as parents are sometimes unable or resistant to express their needs in a second language (English). Also, our staff consults with providers in other programs (for example, therapist consults with TBS coach to discuss client's behaviors in the school and in the home to determine whether client can benefit from a psychiatric referral, etc).

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   Program or Agency-Wide: At various times throughout the year and especially at annual Plan and Budget, we analyze unmet client needs. We take input from staff, from our client's surveys to identify stated needs. We also look at client outcomes to identify what service needs are not being met.

5. In meeting discussions.

6. We as an agency continue to evaluate service needs through our own work, as well as by collaborating with other agencies to determine these gaps.

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2. Via individual supervision.
3. For example, since our staffs are not trained to administer the 0 - 5 assessment instrument, we will assess and refer these clients to other mental health providers.

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63. Satisfaction surveys, Focus groups, suggestion forms.

64. Through the CQI process: biweekly CQI committee meetings, program based teams (PBTs), and program action teams (PATs). This is also done through the analysis of agency (client and staff) data.

65. If there are gaps in services, the provider will follow up with the client/caregiver by phone or letter to identify the problems/issues that may be interrupting treatment.

66. Wait list review, review of client data versus community data, review of client data versus staff data.

67. Gaps in service are identified through client surveys where clients are called by a non-clinician and asked questions regarding delivery of service, client access, and cultural competency. Information gleaned is shared with program directors and trainings are enhanced to meet identified needs.

68. Utilize consumer and staff feedback to decrease gaps in service needs.

69. Annual Accessibility Plan identifies barriers to services including gaps in services and plans for improvement.

70. Not sure.

71. Case conferences, QA meetings, annual planning, treatment planning meetings, and strategic planning.

72. Teaming and cross walking between internal programs and liaison with local CSWs, POs, teachers, etc.

73. We regularly survey parents (in English and Spanish) asking them to indicate services they would like to have.

74. We recently conducted both community wide and client needs assessment surveys.

75. Through MHSA data collection for CSS.

76. We have a weekly meeting attended by all therapists, the biller, office staff, the QA, and the Clinical Coordinator. Program or case specific deficits are discussed to address improvements/corrections. At this time, we are learning to apply our EBP where appropriate and budget our CGF funds in a way that allows us to be more flexible with the cases that need special attention but cannot be served by the EBP in which we are trained.

77. Satisfaction questionnaires, surveys, advisory boards, community input.

78. Review of client demographics from our referral data collection and well as information gathered within intake procedures.

79. Comparison to Census data to actual consumer breakdown of those WCIL services.

80. We collect demographic data and regularly review the level of requests for services provided in languages other than English.

81. Based on the surveys handed to the clients.

82. Gaps in service delivery are determined through the Quality Assurance team and continuum.

10. How do providers in your Legal Entity reduce disparities in service delivery?

Please provide examples in the space below.

1. Evaluate disparities in our internal QA/QI, and make changes accordingly.

2. We try to meet the needs of all our consumers by assessing what their needs are, and considering which provider in the agency would be most effective, and by referring out if we or the consumer thinks we don't have the capacity to be effective.

3. As part of a legal entity that consistently strives to reduce disparities in service delivery staffs are encouraged to go the extra mile to reach out to families and clients and deliver high quality mental health services. Our staff's bilingual skills and professional/personal background permit them to interact and communicate with parents and children in their native/second language. Our agency promotes and supports staff trainings in cultural competency and better understanding of diversity and particular needs of our target population.

   Our legal entity has also received grants from outside sources, so that we can provide services to Non Medi-Cal students in the school districts we provide services in, parent groups and so that we can assist parents with advocacy for services for their child or children.

4. Individual client basis: see if any gaps or disparities exist and then identify new treatment plan goals both for therapy and for case management. Program or Agency-Wide: Address disparities with annual plan goals and hold program staff accountable. This has become more difficult with funding restrictions like CPE and funding cuts. Indigent clients have the biggest disparities in service delivery due to funding shortages.

5. Through meeting discussions.

6. We try to reduce disparities by training and hiring new staff who are competent in these areas, as well as collaborating with other agencies to help those in need.

7. Provider will maintain an adequate level of staffing to have the ability to provide consistent services to clients in needs.

8. BRIDGES pays attention to the language and cultural needs at the beginning assessment. If we are able to "meet the client’s needs" we provide the services; if we determine that the language need is greater than our capability we partner with resources in the community and refer as needed.

9. Through policy & procedure manuals, group supervision, and training in-services.

10. We only serve low-income clients, as our clients must have full-scope Medi-Cal to be able to qualify for services. As such, we believe we are reducing disparities in service delivery. In addition, we provide outreach to other agencies in the community that serve underserved populations to be able to meet this community's needs.

11. Efforts to seek funding for identified needs.

12. Our agency conducts outreach, provides an array of social services and established a family center in a high need, low-income primarily Spanish Speaking Housing complex. All staff is bilingual, bi-cultural, and is trained in addressing concerns such as Public Charge Issues in seeking services for their families.

13. All staff trainings throughout the year, weekly supervision and on an as needed basis.

14. Remain committed to training in effective culturally competent services.

15. Conduct active outreach and provide linguistically and culturally competent services.

16. The agency noticed a need for Spanish speaking therapists and case managers and has focused on this during the hiring process. As a result the agency has greatly increased the number of Spanish-speaking therapists. A majority of the administrative staff and case managers also speak Spanish.

17. By providing information to the community through community health fairs, other providers in the community, through the school system, and faith based organizations. This may include giving presentations about mental illness, setting up a booth at a health or farmers market, etc.

18. By having diversity among the staff at all levels.

19. By hiring staff who provide culturally and linguistically competent services.

20. Network with other provider agencies. Partner with DMH program resources, such as FSP.

21. When consumers express needs, staff connects them to the resources most responsive to those needs, and when there are none available, work in partnership with consumers to create those resources (such as having volunteers translate support group literature so consumers can start a particular group in another language.)

22. By identifying changing needs and addressing any gaps in services (as in the example above.)

23. Identify gaps and if the service delivery cannot be provided within the Legal Entity, then resources are utilized in the community.

24. By assessing client service needs during intake.

25. We provide services in the home, school or community, wherever best fits the family's needs and preferences. We invite consumers to address our staff at meetings, and to participate on the Parent Advisory Board. We employ parent partners to help engage families in services and to represent their voice and choice throughout the treatment process.

26. We develop program designs adapted for the language and culture needs of the community from existing models and published best practices; identify appropriate potential funding sources; and apply for resources to implement the new program, program component, or service enhancement.

27. Monitor referrals and allocate resources to meet community need.

28. Continuous Quality Improvement process.

29. We actively recruit bilingual staff and provide much of our services in clients' school, home and community environment. Staffs are provided with supervision that gives them the foundation to work in these environments and meet the clients where they are.

30. Attempts are made to staff the program appropriately. This has resulted in more than 50% of the service delivery staff being bi lingual in Spanish and 50% bicultural.

31. Directive Supervision and Leadership Team planning.

32. Any disparities indentified by management staff are reported to DMH through QIC or Executive management meetings.

33. Consumer needs are determined on an individual basis, and the treatment planning is a collaborative action between the clinician and the consumer...the consumer informs course of treatment.

    Additionally, in-service trainings are provided to the clinic personnel on a continuous basis, regarding cultural sensitivity and working with non-English speaking clients. The specific training topics will adjust according to the population make-up of the clinic and the corresponding need to accommodate their needs. Highly knowledgeable PhD's and mental health professionals specializing in cultural and linguistic issues provide all in-service trainings. In-service trainings to include some of the following topics: Cultural Diversity, Advances and Treatment of human sexuality, Sexual

Harassment Prevention, Treatment of the Elderly, as well as utilizing relevant trainings provided by DMH's Training and Cultural Competency Bureau.

34. We utilize graduate level interns to supplement bi-lingual services to our target population.

35. Through hiring staff with the needed language skills, and the needed cultural sensitivity.
Through training in cultural sensitivity. Through culturally sensitive outreach and engagement with client groups who are underserved.

36. Apply for grants, government funding, so we can increase services financially. Manager's review and problems solve on how to resolve disparities weekly.

37. We don't have disparities in service delivery except for underfunding to serve the underserved.

38. HFLF provides access to translation services, assists with linkage to additional language/cultural specific services, etc.

39. being responsive to needs expressed by consumers and staff, seeking new funding, redefining services

40. We have acquired funding that allows us to service the uninsured population, primarily the Korean American community who are one of the highest uninsured ethnic groups in LA County. We strongly believe this is one barrier that confronts families from accessing mental health services.

41. We work with our program staff and clients to make sure the service needs of all of our clients are met by us or through linkages.

42. Hiring practices reflect the student population we serve and provide services to students referred by schools, regardless of ability to pay.

43. Interdisciplinary Team Meetings are held to discuss all cases, in addition to survey results. This information is gathered, and services are adjusted if needed. This is done to ensure that all services that are being provided are equitable, fair, and culturally competent.

44. We hire staff to reflect our target groups.

45. Through changes to the ways in which services are delivered in response to client feedback and suggestions.

46. Attempt to outreach to all local school and participate in SPA 4 events to outreach.

47. Primarily through bilingual or bicultural staff we increase access. We also use videoconferencing to provide linguistic access over our three sites.

48. Pacific Clinics has extensive scheduled training opportunities through the Training Institute. Trainings are provided by existing skilled staff/employees or other external professionals

49. Agency goes in length to hire individuals with skills and cultural background in accordance with client population needs and services rendered.

50. Not tracked.

51. All staff understands and signs a non-discrimination policy upon employment. One of the agency's values is respecting and embracing differences as we support individuals in reaching their fullest potential. This value is deeply rooted in our work ethic and how we provide services to our clients.

52. By outreaching to UN/underserved communities and providing welcoming, culturally competent services.

53. The Center has a Cultural Competency Plan and an Accessibility Plan which reduces disparities in services.

54. Maintaining a large number of bilingual staff and contracts with translators.

55. All SHIELDS staff is required to ensure that their clients receive Quality Care as well as provided access to available resources both within SHIELDS and in the community. SHIELDS utilizes community outreach services in order to engage client's in the process of treatment and when the engagement is more challenging SHIELDS will go out to the community to meet the client and help make that connection with the agency. In order for clients to be discharged the case must be reviewed and the d/c must be approved by a clinical supervisor.
    SHIELDS mental health programs provide services pro bono to uninsured clients who cannot afford to pay for their treatment. If clients have private insurance, our staffs are trained to assist them in accessing mental health services through their insurance provider. For clients who are eligible for medical or Healthy families, SHIELDS will asset them with the application process and working with DPSS.
    SHIELDS attempts to hire as many bi-cultural, bilingual staff as possible and subsequent to hiring provides on-going training to ensure cultural competency amongst staff. SHIELDS have several levels of supervision which allow for oversight of programs in order to ensure that quality services are provided.

56. After identifying potential gaps, staff works collectively to determine how to best meet the needs to reduce any disparities in service delivery.

57. Through regular trainings and supervision.

58. Clinicians work primarily in the field- providing services to clients within their home environments whenever possible. Clinicians will provide referral and linkage to needed services outside of their domain.

59. Clients are provided linguistically appropriate services by clinicians fluent in the two languages we have available.

60. By maintaining cultural competency.

61. Ongoing attention to all relevant data sources, incl. monitoring service engagement and retention stats by age, gender & ethnicity. Staff self-assessments and team discussions to increase awareness. Infusion of cult. Competency topics across other trainings. Maintaining cult comp. topics for regular review in CQI.

62. When we get to critical mass of needing non-English speaking staff we will recruit for that population.

63. Make a concerted effort in hiring culturally competent or sensitive staff.

64. By providing individual and group supervision I which cultural and language is addressed. By completing client and staff satisfaction surveys and by providing client and staff with a venue to report complaints and concerns regarding culture and/or language. During supervision it is also discussed whether the consumer could identify with the provider.

65. With up front Intakes to assistance the families to understand how we can partner with the family to meet their needs.

66. Hiring practices and training.

67. Ongoing Clinical trainings serve to reduce disparity in the delivery of service. When disparities exist, program directors address issues through supervision and trainings.

68. Continue to recruit bicultural & bilingual staff. Utilize trainings from LA Co. DMH. Utilize feedback from LA Co. DMH regarding reducing disparities in service delivery. Apply for new programming aimed to reduce disparities in service delivery. Adjusted all programs to deliver 100% of services in the field to accommodate consumer needs.

69. Use of bilingual staff or interpreters in working with Spanish speaking clients or families. Services are provided in the location of client choice including home, school, or other community venue. To increase access offer services in 22 schools and DV shelter.

70. Try to meet the client's needs in any way that is doable and realistic. Obtain information and translation in other languages.

71. We hire a culturally diverse staff and pursue funding opportunities that address service disparities. For instance, we were awarded a CDC grant targeting HIV positive and high risk negatives for men of color and Latinos.

72. Recruit representative staff, cross train staff, encourage voice and choice among staff to initiate parallel process. Identify marginalized populations, solicit information from DCFS re reasons for referral and high risk populations, suspend judgment and engage families where they are, focus on strength based interventions that are culturally appropriate. Education and awareness are key factors, so making sure staffs at every level are involved in training and community engagement. Attend health fairs and community events; provide information in key threshold languages.

73. We provide services to clients in the language with which they are most comfortable.

74. Through trainings and providing culturally appropriate services.

75. As stated above, cases are discussed weekly in our Mental Health Services meeting. Schedules are discussed, services are increased (time wise), decreased, modified, etc. Groups are added where appropriate. Other team members may be included and consulted depending on the disparity including the family, the group home staff, school staff, etc.

76. Satisfaction questionnaires, surveys, advisory boards, community input.

77. To the best of our ability, we hire and retain staff (and interns/trainees) who are culturally and linguistically compatible with our client demographic.

78. We match bi-lingual staff to clients that prefer services in their language.

79. Unclear question.

80. We rarely get requests for service delivery in languages other than English.

81. Attending trainings provided on-site and by DMH including required CEUs as per each clinicians licensing board.

82. This organization uses corrective action to address disparities.

11. Based on the knowledge of providers in your Legal Entity providing culturally and/or linguistically competent services, what are a few lessons learned that could enhance the delivery of culturally and linguistically competent services?

1. Finding and providing good child care during groups, to keep the members attending.

2. Ask the client about their wants rather than making assumptions, encourage the client to give feedback about what is effective for them, address potential cultural issues with clients instead of ignoring them.

3. Schools/Academic entities could facilitate parents/students access to bilingual staff in regards to IEPs, SST meetings, and regular contact with school principals/administrators. Our staffs often hear grievances from parents and students that feel unheard due to the struggle to communicate their thoughts and feelings in English.

   Bilingual service providers might benefit from regular trainings/discussions on cultural and linguistic considerations as the various ethnic groups served by our legal entity are unique and continue instruction in ways to better deliver services seems beneficial.
   * Listen carefully to each client/family regarding their cultural experience and world view without assuming that you understand them because you are all Hispanic. Each Latin American country is very different, so educate yourself regarding a client's culture and heritage particularly if they come from a different country of origin than you do.

4. Speak with and survey clients about their cultural and linguistic needs, and about what services they wish to have that we are not currently providing.

5. Learned to be sensitive to others needs.

6. List of agencies with their language capabilities have been very helpful in enhancing the delivery of culturally and linguistically competent services.

7. Try to conduct comprehensive screening and referral to meet the needs of the client. Cultural Competency is much broader than just language capability. If we are unable to meet the needs of the client then our Agency will work to refer client to more appropriate setting.

8. To encourage other nationalities to become interested in the mental health field, and possibly focus recruitment towards other specific ethnic groups.

9. We recognize that bilingual capability is not always effective without services being provided by bicultural staff as well.

10. We work to make sure that clients understand the nature of treatment, as many are unfamiliar with mental health services. We also work to process any preconceived notions of mental health treatment and stigma that may be a part of a particular cultural group. Clients may have a certain fear due to lack of knowledge about types of services provided.

11. More classes/training provided locally in learning another language, particularly with clinically relevant terminology.

12. Services need to be community based at locations that are comfortable and convenient for the family. Mental Health Programs must be imbedded within other social service programs and active face-to-face outreach needs to occur. Agencies must make a commitment to stay in the community served long-term as many communities feel that agencies come and stay for the duration of the grant and then leave. This leaves families less willing to participate when a new provider comes along.

13. We want to continue to address any issues or concerns promptly and discuss issues, however uncomfortable in weekly supervision.

14. Must be consistent focus of administration and incentives required to expand staff competence.

15. All EBT's need to be closely examined for cultural fit and modified where necessary; Being of the same ethnicity does not guarantee culturally competent clinical services, nor does being of a different ethnicity preclude it; Social class differences are often overlooked as a barrier to effective relationship building.

16. Maintaining current level of Spanish-speaking staff.

17. There is no cookie cutter approach, every family and beneficiary are different. Staff needs to be open at the start of treatment and lay the foundation that they will be educated by the family or client about their/his/her culture during the therapy relationship and encourage the client to disclose if there are concerns or issues that come up during the therapeutic relationship with the staff. Staff also should be willing to do extra research via internet and/or consulting with another staff from the culture.

18. Encourage hiring practices that addresses the various cultures and linguistic needs of the community we serve.

19. Provision of partial day treatment services to children and youth might prevent psychiatric hospitalizations. Information or public service announcements via major media resources (in particular radio for the Latino population) about the nature of children's mental health needs and the range of services available via provider agencies.

20. Consumers who need the resource are the best ones to help develop that resource (such as self-help support groups, housing).

21. It is important to recognize and respond to changing demographics of the geographical area you serve.

22. It is difficult to provide translation services over a phone translation service, but it is preferable to not being able to provide services to clients.

23. More trainings and workshops on these topics. continued outreach in hiring workers from disadvantaged populations

24. The ability to speak the same language as the family being served does not in itself constitute cultural competency. We have learned that treating all families' with respect, being open to learning from them and meeting them on their own terms is the most effective way to improve cultural competency. Staff meetings and other forums are dedicated to discussing and evaluating our successes and opportunities for growth, and staff is encouraged to speak openly about what has worked and what hasn't.

    Our Parent Advisory Board has been a wonderful way to hear directly from consumers about the services we deliver, what has helped in treatment and what has not.
    Agencies must adopt a culture of openness and constructive feedback in order to continually improve in this area.

25. Professionals who have in depth experience in the home country of Filipinos and how mental health problems are addressed based on Filipino notions of the individual and society.

26. Involvement of stakeholders and community partners is important. Be open to change and stay ready to adapt to consumer needs.

27. Hiring our own on call? PT staff in specifies languages as the need arise.

28. We are specifically very careful that our Front Office and Intake staffs are bilingual and that they provide excellent customer service. Clients have said that this makes a very good impression and makes them more comfortable seeking services here.

29. It is important to recruit and hire staffs that are not only bilingual but also bicultural and to provide ongoing training in cultural competencies for the variety of cultures served.

30. The aggressive use of interpreters during patient advisement.

31. Bi-lingual does not equal cultural competency.

32. There are the resources in the County to deliver most services needed; the challenge is making all providers aware. I think we are doing a much better job!

33. Incentives may be helpful in attracting more bi-lingual staff.

34. Hire and retain culturally diverse staff.
Share cultural stories among staff.
Conduct trainings on working with different cultural groups.
Ask about cultural issues in an ongoing manner, in treatment teams and supervision.

35. Be more visible in the community that we serve by attending community events and functions.

36. We have learned that having very little indigent funding has made it very difficult to meet the needs of non-insured, non-English speaking Consumers. We are located in a poverty area of the San Fernando Valley.

37. Cross cultural training within the agency.

38. Outreach and education must be included in the service delivery system. With the immigrant community the stigma or mental health is still a tremendous barrier to treatment. Shared language does not equate to shared cultural experiences (i.e. families from Central America share Spanish as a common language but vary on cultural and historical experiences.) For Korean American families, the acculturation level is a major factor in the treatment approach.

39. We serve many cultures, which are not often talked about. For example, homeless, poor, drug, street, HIV, transgender. We have learned many lessons yet would like more resources and training to further our competence.

40. A culturally competent service are not necessarily based on the service provider being of the same cultural or ethnic background, but has more to do with the service providers ability to make connections with the child and/or family. It is important for any service provider to be culturally sensitive, but this comes through engagement, asking questions, and being open to understanding a person's cultural perspective. Barriers do occur when there is a language difference, and in these cases, offering services in a person's language is most appropriate. McKinley does provide services in languages that a client is most comfortable, but we have also had great success with treatment even if there are cultural differences. Ultimately, good service provision is about the relationship that is built, and the willingness of the service provider to extend them-selves beyond what they feel comfortable with. It is also important that service providers learn about other cultures, so they do not provide services through their own cultural lenses.

41. We became aware that treatment staff didn't know about the other staff language capacity. We are working on improved communication around this issue.

42. 1) Importance of meeting clients where they are at; 2) Importance of assisting clients with multiple disabilities; 3) Importance of understanding the needs of older indigent client.

43. More second language therapists.

44. Be able to bill for interpretation while providing a service and translation of materials. It's "insane" to mandate cultural and linguistic competency and not be allowed to bill to provide that service. This limits an agency's ability to work with underserved populations. Allow funding to hire non-citizen staff as many Asian Americans are not bilingual. The workforce shortage issue is critical. Open up the WET funding faster so bilingual staff in an agency can go to school for advanced degrees while working. Too many agencies have one or two staff, not necessarily clinical staff, which are bilingual and therefore feel they are linguistically and culturally competent. APIs wouldn't go there because there isn't a comfort level with the staff. However those agencies are funded to provide API services and don't provide them.

45. Within each cultural group, there are differences that can be addressed; for example, Latinos from South American may present different from Latinos in the Central or European regions. The same is true for the differences among Asian and individuals of African descent.

46. Newly immigrated clients from other countries have some difficulties acculturating to the American way of life.

47. Need more bilingual staff/ engagement is better for families when services delivered in primary language. All staff needs consistent and frequent training. Environment must have transparent and welcoming cultural/ethnic decorations, signage etc. Front desk staff must be bilingual and bicultural.

48. The importance of remaining open to understanding what culture means to the individual and not making any assumptions about the role that it plays in someone's life. It's important to understand the individual's perspective.

49. Cultural competence is not about "treating everybody equally." It is about recognizing that everyone has the right to high quality, effective, welcoming services that are responsive to the preferences, needs and strengths of each individual and family within their cultural context. This concept is still not widely understood and more training (with self reflection) is needed.

50. 1. When staff has to initiate a DCFS or child abuse report, they have to be aware of the cultural issues it brings up in certain cultures.

2. Staff has to become more sensitive and aware of ways to help persons with gender identity issues to integrate into mainstream.

51. Make all stakeholder documentation available in Spanish so that when our families have to interact with other departments the information is more easily accessible.

52. The issue of cultural competency is a vital, complicated and at times, volatile issue to be reckoned with in the provision of services. While most staff does not consider themselves as racially biased, they may be unaware of their own behaviors and attitudes which can negatively impact their clients. In discussing these issues, it is important to set the stage for having a non-judgmental, non-attacking open discussion where staff feels that they can safely share their thoughts and experiences. Trainings of this nature cannot be accomplished in a single meeting, rather there must be an on-going dialogue and focus on these issues. In addition, factors such as socio-economic status, family values and gender also have great influence on each individual and family experience; therefore one cannot generalize across or within ethnic groups.

53. With the switch to Evidence Based Practices we will need to monitor how these translate to different cultural and linguistic populations.

54. Ensure that the program has an accurate number of bi lingual staff to meet the needs of the community.

55. Providers have often had to learn vocabulary specific to Mental Health services i.e. Psycho-education.

56. With our Deaf and Hard of Hearing clients we have learned that many other DMH directly operated and contracted agencies are unwilling to take clients who need ASL. Because of this we have clients coming to us from all over the county. Some clients take 3-4 buses and take up to 4 hours to come to us for a 30 minute psychiatry appointment. Many times we have tried to refer clients back to their own SPA with little success.

57. A diverse staffing pattern is helpful in enhancing culturally competent services.

58. Institutionalize expectations -- horizontal integration across all "levers and tools" from leadership paying attention, staffing practices, written policies and procedures, annual plans and projects, to training focus, QA probes, outcomes analysis.

59. Clients at times prefer to converse in their primary language but also are comfortable speaking English in sessions.

60. All staff (including Maintenance and dietary) need to be included in diversity training.

61. Developing a Spa 6 initiative to attract and retain competent bilingual staff.

62. More funding for outreach outside of an FSP program.

63. Trainings that include teaching clinicians how to talk to clients about cultural and linguistic needs including not making assumptions about cultural or linguistic needs.

64. Make when hiring all staff that they also possess the clinical skills and work attitude to provide effective, caring services.

65. Via a grant from the Robert Wood Johnson Foundation for which we provided services to uninsured, immigrant student and families at Norwood Elementary School, we found immigrant families are more receptive to services when we included parents in service planning, implementation, and evaluation at the school. Parents were trained in outreach and advocacy and educated other parents to reduce fear of discovery and deportation when seeking services, reduce stigma of seeking mental health services, and promote the benefits of mental health services for their children.

66. Diversify funding streams to reflect diversity.

67. More consumer groups. There is nothing as impactful as a consumer sharing what works and what doesn't work. The lessons are often universally applicable. It can address cultural nuances, and cross cultural similarities.

68. To never assume a client is comfortable with a particular intervention just because they have not complained. We have learned to ask for feedback on a regular basis to ensure that services are culturally sensitive.

69. One major lesson providers learn is that culture does not only refer to someone's language, land of origin, etc. To more appropriately serve the Trinity El Monte population (male adolescents 13-18 on Probation), we have added such trainings as gang culture, drug related trainings and others which help us try to understand some of the behaviors seen in the population we serve. We have had some clients who are gay or questioning and will attend these trainings in addition to the standard LA DMH events addressing the needs of the Latino, Asian, and other populations in an effort to better serve all populations who come through our doors.

70. Consumers that are involved in cultural services tend to do better than consumers not as involved.

71. The most effective therapist and translators are those who grew up with Spanish as their first language or family language.

72. Stigma is not a concept easily conveyed in the Latino culture.

73. Establish a cultural and linguistic competence training program inclusive of overview training for all staff and tailored trainings for staff based on job function and level of knowledge and expertise. Additionally, we develop performance indicators related to the delivery of cultural and linguistic competence and include them in performance reviews and professional development plans. Through demographics analysis, Eldorado assesses the linguistic capacity and needs of service providers and support staff. Eldorado organizes and implements one community engagement and/or outreach activity at least semi-annually to facilitate awareness of mental health issues and services within the community.

74. Providers need to be trained on the cultural competence continuum.

12. Based on the knowledge of providers in your Legal Entity providing culturally and/or linguistically competent services, what type of technical assistance could enhance the delivery of culturally and linguistically competent services?

1. Additional trainings that are ethnic/culturally specific or address a specific topic such as proving parenting, addressing mono-lingual employment, treatment planning that includes addressing cultural customs/needs.

2. We would like LACDMH to provide the cultural competence trainings they have offered in the past. It is most helpful when the training is only 1 day long, and offered in all Service Areas to reduce the amount of time staff is unavailable to provide direct services.

3. Facilitating access to the internet in the many school sites where we deliver services might promote a faster process regarding linking students/families with services that might be identified and contacted through the internet.

   Perhaps further resources (pamphlets, Facts sheets, videos, etc) in Spanish, in which they educate clients/families regarding the therapy process and various mental health disorders.

4. Potentially additional training; also a county-wide conference on cultural competency issues with panels of providers, clients, parents, etc.

5. Cultural literature.

6. More training's should be offered to help therapists, not just interpreters, be able to use medical terms in various languages.

7. Translation assistance for clients and documents in other languages. Translation services for brochures and other written documents.

8. Have a hearing/visually impaired phone system set up to help them access to the appropriate services within our program.

9. Developing network of agencies struggling with this issue due to budgetary restrictions and other who could meet and exchange creative ideas for implementing culturally competent services in a way that blends with other services and funding availability.

10. Not all DMH forms are in other languages. It might be helpful (i.e., CCCP).

11. Geographically based classes/training in language acquisition and immersion classes.

12. I think that the most important assistance that could be given is in building strong collaborative relationships with other stakeholders in the community

so that service delivery is coordinated for the families who are often overwhelmed and hesitant to enroll in new programs.

13. Advocacy at policy level to improve reimbursement for culturally competent evidence based practices.

14. We provide much training to staff already but always appreciate other training opportunities, especially when they are free or low cost; Translation resources to help us develop materials to expand services within the Korean community.

15. I am unclear as to what kinds of technical assistance would be available.

16. Have DMH provide all standardized forms, policies & procedures in threshold languages, as most contract providers have limited means of supporting/furthering competencies.

17. I think really the people to ask on this are actually the consumers themselves. For providers, the key is training to become aware of our own biases and perceptions which might taint how we interact with various cultures.

18. Provide trainers in Cultural competence.

19. Provide the required Evidence-Based Practices Manuals in all threshold languages.

20. Greater access/availability of culturally competent psychiatric/medical practitioners.
    Trainings on culturally competent practice for children and adolescents
    Standards of practice/practice parameters for mental health treatment of ethnically and culturally diver's children and youth.
    Trainings on the common elements of culturally competent EBP's.

21. Trainings on how to start a self-help support group would help create more diverse support groups in the areas where they are needed. Training on how to avoid communicating the stigma mental health consumers typically experience in institutions (such as being greeted by an armed, uniformed guard, talking to staff across desks or through bullet-proof glass, having separate bathrooms and/or workspaces and being dominated by signs that express warnings and rules rather than welcoming, acknowledging and celebrating people.)

22. Assistance with translation of forms/informational materials in different languages.
23. DMH providing Spanish version forms of their documents used for services.

24. Having programs that could translate text into other languages.

25. Testing/Certification in medical/therapeutic terminology both written and spoken for staff.

26. The use of cultural anthropological definitions of cultural that go beyond a simplistic notion of language translation and core values - to actual examples of how cultural beliefs from the specific society impact prognoses for treatment or the construction of solutions to problems or barriers.

27. Training is how various cultures view mental health and treatment would be valuable.

28. Language line has been helpful as well as 211 resource Guide.

29. Funding for classes to help partially bilingual staff brush up on their language skills. Some of our staff learned their language as children but do not have the words to express mental health issues easily.

30. Increasing bilingual staff.

31. ACCESS line in other languages?

32. Easy to use on line resource directory.

33. User-friendly automated translation software to convert documents into another language.

34. Having a speaker come to our agency and teach about working with different cultural groups.

35. We are serving our consumers competently and linguistically with our multi-cultural staff.

36. Additional training opportunities through DMH.

37. Access to a pool of applicants with cultural competency.

38. Support with translation of pertinent materials. DMH needs to widen the threshold language capacity for client related forms. In regards to EBP's the department should advocate for other promising practices for underserved communities, such as Asian and Pacific Islanders.

39. Training re: Transgender Sensitivity and working with folks who are HIV positive.

40. Training and EBP’s that consider cultural and linguistically competent services, on going training and support.

41. Translation is important both in language and in writing. McKinley has both.

42. Language translation of our documents!

43. Translation services for written materials.

44. We should be doing more.

45. Unknown.

46. We provide a lot of technical assistance already to our staff such as videoconferencing, laptops, etc. The biggest need is materials and DMH forms translated into more API languages. QA does not gather data in many API languages so DMH is not getting a full picture of client satisfaction or needs.

47. Continuous recruitment of staff that have the linguistic and cultural skills. Keeping abreast of the trends and composition of the consumers that we serve.

48. Continued staff training and culturally sensitive staff across the board in the department will go a long way in enhancing culturally sensitive services to clients and their families.

49. More training specific to EBP and use with cultural groups.

50. Ongoing training and forums to discuss integrating culturally and/or linguistically competent services into all aspects of service delivery.

51. Assistance with training, particularly web-based trainings.

52. Standardize forms available in Spanish via computer and/or internet.

53. It would have been helpful to have been provided additional training slots for the EBP's so that our agency would be able to provide all EBP's in all the languages we service.

54. Translation services for different dialects/ trainings for bilingual staff addressing vocabulary specific to mental health interventions.

55. If the county could have a better system to provide ASL services to clients it may resolve the problem below. We have heard from other agencies that when they have tried to access the county interpreters but they don't show up or they have to schedule with 2 weeks notice which makes it difficult for clients who need to reschedule appointments.

56. We are pleased to have invested in CBMCS. Having internal trainers who know how to run this curriculum, break it into manageable deliverables, and facilitate the discussions among staff teams is a huge step forward.

Having easily accessible actuarial data at the county level, such as emerged through PEI planning has also been very helpful.

A point person to contact in the county who would help facilitate low occurrence needs re: language translations/interpreters would be helpful. E.g., who to turn to when referred a family who is monolingual in an uncommon language?

57. Understanding how to offer services to a primarily homogeneous population.

58. The effects of gang influences on the family in various cultures.

59. An easily accessible and user friendly translation phone program to assist with translation for families who cannot be accommodated with a clinician of their preferred language.

60. To have one log for all providers to collect this information on a monthly basis or as clients are opened in the IS system.

61. Availability of DMH documents in all threshold languages.

62. Continue to provide trainings, webinars very efficient, to support furthering the cultural competency training of staff.

63. More training in providing field based services, beyond issues of safety, but rather treatment models that can be used in natural settings.

Training on use of natural supports to enhance service delivery efforts. Use of existing parent groups to educate on issues of stigma, fear of deportation for immigrant families, benefits of mental health services.

64. Training and information on disparities in delivery and cultural gaps.

65. Cultural competency training to address Latino and African American populations, as well as transgender training.

66. Statistically valid surveys in the participant's language to measure outcomes. Funded Prevention services not tied to EPSDT so that anyone can join a parenting, support, skills group. That would enable us to engage groups in local centers, churches, schools, recreation facilities, parks etc.

67. Having all DMH forms available in Spanish would be extremely helpful.

68. (Free) Trainings.

69. One help might be to include a link on the DMH website which allows Providers to post their job openings in terms of needed culture categories like Spanish speaking or other language.

70. Trainings.

71. Mostly in the area of Case Management/Resource Linkages: while some community resources offer assistance in Spanish, it is not easy to access or the services do not offer any assistance in Spanish.

72. Funding to use in document translation and to compensate staff with bi-lingual/bi-cultural pay differentials.

73. More training's for clinicians as well as the entire staff on how to address important treatment goals with the client.

74. Access to more county provided training resources.